Maternal and Child Health Services
Title V Block Grant

State Narrative for South Dakota

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Copies of the assurances and certifications are provided as an attachment to this section. The originals are maintained in the State Maternal and Child (MCH) program's central office.

The MCH program further assures it will: (1) use funds only for the purposes specified; (2) identify and apply a fair method to allocate funds to groups and localities; (3) apply guidelines for appropriateness and frequency of referrals; (4) use funds only to carry out the purposes of this title; (5) publish charges for services, not impose charges for low income, and adjust charges for income and resources; and (6) at least every 2 years audit expenditures and submit a copy of the audit report to the Secretary.

An attachment is included in this section.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

State performance measures were developed based on the state's comprehensive needs assessment. The South Dakota Department of Health (DOH) made the FY 2011 MCH block grant available for public review and comment via the DOH website at doh.sd.gov/news. A summary of the plan was put on the website on May 3, 2010 with comments due back to the DOH by June 30, 2010. Information on how to obtain a complete copy of the application for review was also provided on the website. No comments were received. The MCH program interacts daily with the MCH population and partners which allows the MCH program to respond to any identified areas of need and build those recommendations into the annual plan prior to the block grant being available for public review.

The MCH program works throughout the year with many different programs and stakeholders around the state including DOH programs (i.e., Nutrition/Physical Activity, Tobacco Prevention, Family Planning, Diabetes, etc.), Department of Social Service (DSS), Department of Human Services (DHS), Department of Education (DOE), Department of Public Safety (DPS), Department of Transportation (DOT), Delta Dental, Dakota Smiles Mobile Dental Program, South Dakota Dental Association (SDDA), HELP! Line, respite care, Aberdeen Area Indian Health Services (IHS), Aberdeen Area Tribal Chairman's Health Board (AATCHB), Healthy Start directors, school nurses, University of South Dakota (USD) School of Medicine, Parent Connection (Parent Training and Information Center), USD Center for Disabilities, and pediatric specialists. Through participation in these many different projects and meetings, the MCH program constantly receives informal public input on additional opportunities to collaborate and

improve efforts to serve the MCH population in South Dakota.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Priority needs for the South Dakota MCH block grant are based on the five-year needs assessment completed for the FY 2010-2015 MCH Block Grant cycle. The following priority needs in South Dakota cross the four levels of the public health services pyramid and are measured through both national and state performance measures:

• Reduce unintended pregnancies;
• Improve pregnancy outcomes;
• Reduce infant mortality;
• Reduce morbidity and mortality among children and adolescents;
• Improve adolescent health and reduce risk-taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization);
• Reduce childhood obesity;
• Improve the health of, and services for, children with special health care needs (CSHCN) through comprehensive services and support;
• Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN; and
• Improve state and local surveillance and data collection and evaluation capacity.

The priority needs have not changed from the2005-2010 MCH Block Grant cycle as it was determined the priority needs were still an accurate portrayal of South Dakota.

South Dakota's assessment team included representatives from CYSHCN, WIC, perinatal health, adolescent health, sexual violence prevention, family planning, newborn screening, oral health, tobacco prevention/control, nutrition, epidemiology, and data. The team used national performance measures and health status and capacity indicators as the starting point for the review. Stakeholders were involved to provide additional data and/or clarification.

The assessment was conducted in two phases. In Phase 1, for each area the assessment team looked at population served, trend data, other data sources and identified gaps, strengths, resources, and partners. Based on this review, potential state performance measures were narrowed down to eight. In Phase 2, results of phase 1 were disseminated to public and private stakeholders not represented on the assessment team via focus groups to identify other resources, collaboration opportunities, and identification of possible duplication of efforts. Stakeholders included Healthy SD, Children's Mental Health Initiative, Roadway Safety Committee, Family Planning Workgroup, Parent Connection, Newborn Screening Program medical consultants, Healthy Start, Community Health, and Tobacco Prevention and Control Advisory Committee.

The 2005-2010 needs assessment team used the CAST-5 self assessment tool. This tool was not used for the 2010-2015 assessment. However, the process of looking at MCH population groups by Title V health status and capacity indicators, performance measures, and other quantitative and qualitative data was continued during the 2010-2015 assessment.

Stakeholder involvement began during data review. Other programs and agencies were invited to an assessment meeting to provide additional data and/or clarification specific to a given performance measure. This allowed the core assessment team to better identify gaps in data

collection and strengths and weaknesses of present activities and collaborations to address areas of concern. In addition, stakeholder input was received via focused group presentations. Using opportunities when different working groups and/or committees were meeting, the MCH program gave presentations to share data and request input.

The needs assessment did identify that some of the state performance measures needed to be changed to allow the MCH program to capture additional/different data and realign resources/activities to meet those measures/activities.

SPM 1 - Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion. (Continued)

SPM 2 - Percent of singleton birth mothers who achieve a recommended weight gain during pregnancy. (Continued)

SPM 3 - Percent of pregnant women aged 18 through 24 who smoked during pregnancy. (New)

SPM 4 - Percent of infants exposed to secondhand smoke. (Continued)

SPM 5 - Percent of WIC infants breastfed at 6 months of age. (New)

SPM 6 - Percent of school-aged children and adolescents with a Body Mass Index at or above the 95th percentile. (Continued)

SPM 7 - Percent of high school youth who self-report tobacco use in the past 30 days. (Continued)

SPM 8 - Accidental death rate among adolescents age 15 through 19 years. (New)

Changes made reflect new opportunities to impact our MCH population and overarching priority needs versus a change in the State's capacity to meet the needs.

III. State Overview

A. Overview

South Dakota is one of the nation's most rural areas. According to 2009 U.S. Census estimates, there are 812,383 persons living within its 75,885 square miles -- and average population density of 10.7 people per square mile. Only three cities in the state have a population of 25,000 or more. Nearly 60% of South Dakota residents live in small, rural communities of 5,000 or fewer people with a significant number living in communities of fewer than 500 people. Of the state's total population, 88.2% are White, 8.5% are American Indian, and the remaining 3.3% are classified as some other race. Adults 65 and older comprise 14.4% of the population, which is slightly higher than the national average of 12.8%. South Dakota's population continues to migrate to the eastern part of the state.

According to the 2000 Census, 13.2 percent of South Dakotans live below 100 percent of the federal poverty level (FPL) compared to 12.4 percent for the nation. Over 33 percent (33.1%) of South Dakotans live under 200 percent of FPL compared to 29.6 percent for the nation. When looking at poverty levels for counties on Indian reservations in the state, these numbers are significantly higher with the four largest reservations in the state (Cheyenne River, Crow Creek, Pine Ridge, and Rosebud) representing the five poorest counties (Dewey, Ziebach, Buffalo, Shannon and Todd) in South Dakota. The percentage of the population below 100% FPL is: Dewey (Cheyenne River) -- 33.6%; Ziebach (Cheyenne River) -- 49.9%; Buffalo (Crow Creek) -- 56.9%; Shannon (Pine Ridge) -- 52.3%; and Todd (Rosebud) -- 48.3%. The percentage of the population below 200% FPL is: Dewey -- 66.0%; Ziebach -- 72.1%; Buffalo -- 79.9%; Shannon -- 77.7%; and Todd -- 73.4%.

According to the 2009 Census, 24.6 percent of the state's population are children (under the age of 18) while 7.3 percent are age 4 or younger. Nearly 38 percent (37.8%) of the state's female population is considered to be of childbearing age (age 15 through 44). In 2009, there were 12,516 resident pregnancies (24 of those were to women not in the 15-44 year age range). Pregnancies were estimated by totaling resident pregnancies producing at least one live birth, fetal deaths and abortions.

Access to primary care physicians is limited in the state. As of May 2010, there were 1,138 active primary care physicians licensed to practice in South Dakota (family practice -- 533; internal medicine -- 312; pediatrics -- 127; OB/GYN -- 101; general practice -- 65). There are also 818 primary care midlevel providers -- 452 physician assistants, 348 nurse practitioners, and 18 nurse midwives -- located in the state. About two-thirds of the state is designated by the federal government as a Health Professional Shortage Area.

South Dakota has 50 general community hospitals, of which 38 are critical access hospitals (CAHs), as well as five IHS hospitals and three Veterans Administration hospitals. There are 28 federally qualified health centers (FQHCs) and 59 rural health clinics. Twenty-two of the 50 community hospitals are currently licensed for obstetrical services.

The economic status of individuals in the state, particularly in the American Indian population, is a major barrier to access to services. Another factor to consider is transportation to access services. For some, this means traveling great distances (over 50 miles) to see a primary care provider and even further to see a specialist. On the Indian reservations, this problem is further complicated by the lack of a reliable transportation system. The DOH does allow for reimbursement for travel expenses incurred in traveling to specialty care for CYSHCN.

The Temporary Assistance for Needy Families (TANF) program is a temporary public assistance program administered by DSS and the Department of Labor. TANF is a needs-based program for families with children under the age of 18 (or under the age of 19 of the child is in high school) who need financial support due to: (1) death of a parent(s); (2) parent(s) absence from the home;

or (3) physical/mental incapacity or unemployment of parent(s). The primary focus of the state TANF program is to help families help themselves by promoting family responsibility and accountability and encouraging self-sufficiency through work. In state FY 2009, there were 5,012 children receiving TANF benefits.

The state Children's Health Insurance Program (SCHIP) provides health insurance to children under age 19 who meet certain eligibility guidelines. SCHIP covers doctor's appointments, hospital stays, dental/vision services, prescription drugs, mental health care, and other medical services. SCHIP provides health insurance coverage to uninsured children whose family income is up to 200% of FPL. Children who already have private health insurance may also be eligible for SCHIP to pay deductibles, co-payments and other medical services not covered by their private policy. At the end of FY 2009 (ending 09-30-09), the total number of children enrolled in Medicaid and SCHIP was 71,211.

In January 2010, the DOH released its DOH 2020 Initiative which provides a clear, concise blueprint for the future activities of the department. The Initiative outlines the goals and objectives for the department as well as key performance measures which will allow the DOH to monitor progress towards these goals. The Initiative also provides detailed action steps for each goal to help guide department activities. Specific individuals have been assigned the responsibility of leading the action steps needed to attain each of the 12 objectives. A copy of the DOH 2020 Initiative is included as an attachment to this section.

Biannual meetings are held between MCH, IHS, AATCHB, and coordinators from the eight Healthy Start programs in South Dakota (Crow Creek, Lower Brule, Sisseton, Yankton, Pine Ridge, Rosebud, Flandreau, and Cheyenne River). The only tribe in South Dakota without a Healthy Start program is Standing Rock. The group meets to discuss challenges, networking and how to help each other. Areas of discussion have included transportation, sales tax refund on food program; causes of death among the state's American Indian population; tobacco use and tobacco prevention efforts for pregnant mothers and exposure to secondhand smoke by infants and children; metabolic screening; updates on the MCH block grant and data specific to the American Indian population; family planning services and how to obtain pregnancy tests for clients so they are able to be aware of pregnancy earlier to begin prenatal care, Lifeline Linkup (a telephone assistance program in Indian Country that allows households located on tribal lands to have access to affordable telephone services); Children's Special Health Services (CSHS) program services; EPSDT (early and periodic screening, diagnosis, and treatment) overview; child death in South Dakota including data on causes and rates of death among children; FASD project including a discussion of the issues of drinking and pregnancy and the affect on the unborn child; and Women, Infants, and Children (WIC) program.

In May 2006, the Yankton Sioux Tribe received federal funding from CDC for its Tribal PRAMS project. The Tribal PRAMS project will supplement existing vital statistics data as well as data collected through the department's Perinatal Health Risk Assessment survey and will provide an important source of information to help the state get a better understanding of maternal attitudes, behaviors and experiences for American Indian women and their infants in South Dakota. Data can then be used by the state, IHS, tribal health programs, and the Northern Plains Tribal Epidemiology Center to target interventions and programs to help improve the health of American Indian women and infants. The Tribal PRAMS project will also provide essential data to support progress towards achievement of many DOH Title V priority needs and outcome objectives. The MCH Project Director will contribute to the identification of maternal, infant and child health priorities to be addressed in the Tribal PRAMS project, assist in identifying potential uses of data and mechanisms for dissemination as well as incorporate data to improve programs and services for American Indian communities throughout the state.

During the 2010 South Dakota legislative session, no legislation passed directly impacting the MCH population.

The DOH receives $5 million from the cigarette tax for tobacco prevention and control efforts. Funds are used to support cessation and statewide programming, community and school programming, and countermarketing, surveillance/evaluation, and administration. South Dakota offers QuitLine services including coaching, free tobacco cessation products, and three lifetime opportunities for tobacco users to use the QuitLine. South Dakota provides either Chantix or Zyban or patches or gum for QuitLine participants regardless of income. Since it began in January 2002, the QuitLine has assisted over 54,000 South Dakotans in their efforts to quit. Data for 2008 indicates the QuitLine has demonstrated a 43% quit rate vs. 5% for people who try to quit on their own. The department's FY11 tobacco prevention control budget was cut by $1.5 million during the 2010 legislative session.

In May 2010, South Dakota was honored at the National Influenza Vaccine Summit where it received the "Summit Award for Immunization Coalitions/Public Health/Community Campaign" for outstanding efforts and partnerships during the 2009-2010 H1N1 vaccination campaign. In South Dakota, H1N1 vaccination was truly a partnership effort between the state, health systems, hospitals, clinics, schools, colleges, IHS, and community volunteers. The partnership helped South Dakota achieve some of the highest immunization rates in the nation -- vaccinating 34.4% of adults 18 and over for H1N1, the highest percentage in the nation, and had some of the highest coverage rates in several other population groups as well. More than 260,000 South Dakotans were vaccinated. In addition to working with those typical flu vaccine providers, the DOH worked with the three largest health systems to help organize and staff public clinics in the state's larger communities. In other communities, the state relied on local points of dispensing (POD) groups organized by the department to quickly get medications to a large population in the event of a large infectious disease outbreak. DOH "strike teams" gave H1N1 vaccine in communities not served by the health systems or a local POD group, including reservation and tribal lands.

Through collaborative efforts, the MCH program has accomplished the following:

• Served 127 children (1992-present) through the LTFU for the metabolic program to assure children are receiving appropriate care for their metabolic disorder;
• Utilized the Dakota Smiles Mobile Dental Program to see 11,557 children in 66 communities and provided a retail value of over $5 million in dental care since August 2004;
• Held biannual meetings with Healthy Start directors from eight of the reservation areas to address such issues as prenatal care, family planning, tobacco use, FASD, infant mortality, and transportation;
• Provided rapid HIV testing to 424 adolescents 19 years of age and younger that were at high risk due to lifestyles; continued to provide HIV testing for women when they come in for pregnancy tests;
• Provided influenza vaccines free-of-charge to 22,420 children aged 6 months to 18 years through CHN/PHA sites;
• Increased collection of height and weight data from South Dakota schools from 26.9% of the state's students to 29.3%; obtained data on 40,202 students in these schools;
• Provided respite care to 1,462 children (980 families) with chronic medical conditions, developmental disabilities, and serious emotional disturbances;
• Sponsored outreach genetic clinics in two communities in South Dakota to decrease the travel miles and time for families to access these services;
• Implemented a gestational weight gain during pregnancy initiative to provide educational materials/toolkit on adequate pregnancy weight gain to all physicians attending births in South Dakota; and
• Expanded the breastfeeding peer counselor program from three to 10 communities.

One of the biggest challenges for South Dakota and the MCH program continues to be the disparities of the state's American Indian population:

• 46.0% of American Indian women received prenatal care in the first trimester vs. 71.0% for

White women;
• 5-year median infant mortality rate (infant deaths per 1,000 live births) for American Indians is 2.2 times higher than Whites;
• 29.1% of American Indian women smoked during pregnancy vs. 15.9% for Whites;
• 45.7% of American Indian students were overweight/obese vs. 31.8% for White students; and
• The birth rate for teens 18-19 years of age for American Indians was 186.7 per 1,000 women 18-19 years of age vs. 46.4 for Whites.

An attachment is included in this section.

B. Agency Capacity

The DOH is charged with the protection of the public health by appropriate measures set forth and authorized by state law. South Dakota Codified Law (SDCL) 34-1-21 designates the DOH as the sole state agency to receive, administer, and disburse federal Title V monies and authorizes the DOH to adopt rules to administer the Title V program relating to MCH and CYSHCN services. Administrative Rules of South Dakota (ARSD) 44:06 provides guidance on the delivery of services to CYSHCN and outlines general operation of the program, eligibility requirements, providers, family financial participation, claims, and scope of benefits. SDCL 34-24-18 requires all infants born in South Dakota to be screened for phenylketonuria (PKU), hypothyroidism, and galactosemia. ARSD 44:19 contains the rules regulating metabolic screening including screening for biotinidase deficiency, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders fatty acid oxidation disorders, organic acid disorders, and cystic fibrosis.

The Division of Health and Medical Services (HMS) is the health care service delivery arm of the DOH and administers MCH services. HMS consists of three offices.

OFFICE OF FAMILY AND COMMUNITY HEALTH (OFCH) -- OFCH administers the MCH Block Grant for the DOH. OFCH provides leadership and technical assistance to assure systems that promote the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. OFCH staff provide training and ongoing technical assistance to DOH field staff as well as private health care providers who deliver MCH services. Staff are responsible for the development of policies and procedures relevant to the delivery of MCH services for pregnant and postpartum women, infants, children, adolescents, and CYSHCN. OFCH works closely with field staff on data collection needed for federal and state reports as well as for program evaluation.

The CSHS program provides -- Health KiCC (Better Health for Kids with Chronic Conditions) -- provides financial assistance for medical appointments, procedures, treatments, medications, and travel reimbursement for children with certain chronic health conditions. Care coordination services are also available upon request. Health KiCC covers 100% of eligible covered expenses. IF a person is eligible, Health KiCC covers the entire cost of the coverable services after other third party sources are billed. Assistance is limited to $20,000 per year.

The Perinatal program provides direction and technical assistance for primary and preventive care for women and infants including risk assessment and care coordination of pregnant women, perinatal education, prenatal/Bright Start home visits, and education on sudden infant death syndrome (SIDS).

The Newborn Metabolic Screening program helps identify babies who may have a metabolic disorder and alerts the baby's physician to the need for further testing and special care. In 2005, South Dakota expanded the number of mandated newborn disorders to be screened for to include 27 of the 29 American College of Medical Genetics (ACMG) report of core conditions. Of the ACMG report of secondary targets, South Dakota screens for 17 of the 25 deficiencies/ disorders. In addition, South Dakota screens for four deficiencies/disorders not listed on the ACMG report. Cystic fibrosis is also a mandated screen.

The Newborn Hearing Screening program works with hospitals to encourage screening of newborns for hearing loss prior to hospital discharge or by one month of age. The program also works to ensure health care providers and parents are informed about the benefits of early hearing screening and that follow-up is provided to infants referred for further hearing evaluation. The Newborn Hearing Screening program utilizes the Electronic Vital Records and Screening System (EVRSS) to determine which infants have been screened/not screened as well as which infants need rescreening and/or follow-up.

The WIC program promotes and maintains the health and well-being of nutritionally at-risk women, infants and children up to age five. Clients must meet income eligibility and be at nutritional risk. WIC provides nutrition education/counseling, breastfeeding support (i.e., information, breast pumps, breastfeeding peer counselors, etc.), healthy foods, referrals to health care providers and health/social services agencies, and immunizations (if needed).

South Dakota Family Planning (SDFP) offers men and women of childbearing age reproductive health education, contraceptive counseling and methods, physical examinations, and sexually transmitted disease (STD) counseling, testing and treatment. Payment for family planning services is based on a sliding fee schedule according to family size and income.

The Child/Adolescent Health program collaborates on a variety of activities designed to promote health, prevent disease and reduce morbidity and mortality among children and adolescents including abstinence, school health guidance, drug/alcohol prevention, rape prevention, and intentional/unintentional injury prevention.

Community health offices provide professional nursing and nutrition services and coordinate health-related services to individuals, families, and communities across the state. Services include education and referral, immunizations, developmental screenings, management of pregnant women, WIC, family planning, nutrition counseling/ education, and health screenings (i.e., blood pressure, blood sugar, vision, hearing, etc.). In most counties, these services are delivered at state DOH offices. In 11 Public Health Alliance sites, the office coordinates the delivery of services through contracts with local county governments and private health care providers.

OFCH also administers the Bright Start nurse home visiting program which is a community-based program in Sioux Falls, Rapid City, and Pine Ridge providing nurse home visiting services to high-risk families during pregnancy, after delivery, and continuing until the child's third birthday. The program focuses on high-risk pregnant mothers and new parents with limited economic and/or social and health resources. Ideally, the visits begin during the pregnancy but can begin whenever the family is referred to the program. Interventions include: (1) prenatal, maternal, and infant/child health assessments and education; (2) infant/child developmental assessments; (3) parenting education; (4) health, safety, and nutrition education; and (5) linking families with other resources in the community to maximize their overall functioning. The Bright Start home visiting program began in April 2000. In October 2008, one staff person was hired to begin providing Bright Start Home Visiting Service on the Pine Ridge Reservation. This allows the DOH to provide the program to pregnant women at Pine Ridge and allows for continuity of care for American Indian women who are seen through the home visiting program in Rapid City and move between the Pine Ridge Reservation and Rapid City during their participation in the program. In FY 2009, 456 families were served by Bright Start. The goal of the Bright Start program is to enhance the family's ability to care for itself and have a healthy baby. The program helps individuals and families identify strengths and assists the family utilize and build on these strengths and skills. The DOH is currently working with DSS, DOE, and others to complete the needs assessment required by the Patient Protection and Affordable Care Act of 2010.

OFFICE OF HEALTH PROMOTION (OHP) -- OHP coordinates a variety of programs designed to promote health and prevent disease. In addition to the programs below, a chronic disease

epidemiologist provides epidemiological support for the chronic disease and health promotion programs as well as for MCH programs.

The All Women Count! (AWC) Breast and Cervical Cancer Control program coordinates statewide activities to promote early detection of breast and cervical cancer. Mammograms, Pap smears and related exams are available at no cost to eligible women at many physician offices, mammography units, family planning clinics, and other clinics throughout the state. AWC serves women (30-64 years of age for pap smears, 50-64 for mammograms) who are without insurance to pay for screening exams or who have insurance but cannot pay the deductible or co-payment.

The AWC Chronic Disease Screening program is an expansion of the Breast and Cervical Cancer program and includes cardiovascular and diabetes screening for eligible women enrolled in AWC. The expanded program reimburses health care providers for screening, diagnosis, and patient education for diabetes and cardiovascular disease. Women not only are screened for cardiovascular disease and diabetes but also can be seen by a professional for four physical activity and nutrition sessions per year.

The South Dakota Cancer Registry is a statewide population-based cancer registry that collects data on cancer incidence and reports on cancer incidence and mortality.

The Nutrition and Physical Activity program provides resources, technical assistance, and programs to a variety of target audiences such as parents and caregivers, schools/youth organizations, workplaces, communities, and health care providers to help prevent obesity and other chronic diseases. The Nutrition and Physical Activity program collaborates with many DOH programs to address poor nutrition and inadequate physical activity. With the help of a committed group of stakeholders, a "South Dakota State Plan for Nutrition and Physical Activity to Prevent Obesity and Other Chronic Diseases" was released in 2006. It was the first comprehensive plan to increase healthy eating and physical activity as ways to reduce overweight and obesity and their subsequent risk for chronic diseases such as cardiovascular disease, hypertension, and diabetes. The plan was updated and a revision released in April 2010. The full plan can be found on the healthy.sd.gov website.

The Coordinated School Health Program (CSHP) provides technical guidance and services to schools in the areas of nutrition, physical activity, and tobacco use. Its purpose is to expand and strengthen the capacity of state agencies and school districts to plan, carry out, and evaluate coordinated school health programs and address significant health problems that affect adolescents, especially HIV infection, tobacco use, sedentary lifestyle, and dietary habits that result in disease. The program is jointly administered with DOE.

The Diabetes Prevention and Control program designs, implements, and evaluates public health prevention and control strategies to improve access to, and quality of, diabetes education for all persons with diabetes in South Dakota, and delivers a broad range of public health activities to reduce death, disability and costs related to diabetes and its complications. In March 2010, the "South Dakota Diabetes State Plan 2010-2013" to reduce the impact of diabetes was released. The plan was developed by individuals representing health care, advocacy groups, government agencies, tribal health, and quality improvement programs along with people who have diabetes and concerned family members. It details a wide range of activities for the next three years to reduce the impact of diabetes in South Dakota and improve the lives of those with the disease. The ultimate goal of the diabetes plan is to put in place a more effective system of early diagnosis, access to quality care, health promotion, and education so South Dakotans with this disease can live longer, healthier lives. A copy of the plan is available at http://doh.sd.gov/diabetes.

The Oral Health program coordinates activities to increase awareness of the importance of oral health and preventive care, foster community and statewide partnerships to promote oral health and improve access to dental care, and promote the use of innovative and cost effective

approaches to oral health promotion and disease prevention. The program collaborates with numerous internal and external partners to address workforce issues, access to care, and reinforce disease prevention and dental education. In May 2009, 30 key stakeholders developed South Dakota's first ever State Oral Health Plan as a road map to provide guidance for achieving optimal oral health for all.

The Public Health Nutrition program is responsible for developing and managing nutrition activities for the DOH. The State Nutritionist serves as a spokesperson on issues that affect the nutritional health of the state and recommends appropriate nutrition interventions.

The Tobacco Control Program (TCP) coordinates state efforts to prevent young people from starting to use tobacco products, help current tobacco users quit, and reduce non-smokers' exposure to second-hand smoke.

OFFICE OF DISEASE PREVENTION (ODP) -- ODP coordinates infectious disease prevention and control programs. Within ODP, the Immunization Program provides vaccines for South Dakota's children to prevent such childhood diseases as measles, mumps, rubella, varicella, HiB, hepatitis B, and bacterial meningitis. The program also and provides recommendations and education on adult immunizations such as influenza, pneumonia and tetanus. The Immunization program provides vaccine materials, training, and support to both public and private immunization providers in the state and works in partnership with local and statewide coalitions. The South Dakota Immunization Information System (SDIIS) is a computerized software system that allows healthcare providers to share immunization records.

ODP staff investigate sources of STD infections, provide treatment and apply preventive measures to those exposed. Field offices provide confidential counseling and testing for HIV/ AIDS as well as educational materials, training for the public, schools and health care providers, and assistance with health care costs for those with HIV disease. The office provides TB clinics and contracts with the private medical sector for evaluation, treatment and follow-up of TB cases. ODP also conducts disease outbreak investigations in the state.

C. Organizational Structure

The DOH is an executive-level department with the Secretary of Health appointed by, and reporting to, the Governor. The mission of the DOH is to prevent disease and promote health, ensure access to necessary, high quality care at a reasonable cost, and efficiently manage public health resources. As was noted earlier, SDCL 34-1-21 designates the DOH as the sole state agency to receive, administer and distribute federal Title V monies as well as adopt rules to administer the Title V program relating to MCH and CYSHCN.

The DOH is organized into three divisions -- Health and Medical Services, Administration and Health Systems Development and Regulation. The State Epidemiologist reports directly to the Secretary of Health. As was mentioned above, HMS is the health care service delivery arm of the DOH. A detailed description of HMS offices and activities is provided under "B. Agency Capacity".

The Division of Administration provides centralized support to DOH programs including financial management, computer systems, communications, health planning, legislative coordination, grant writing, health information technology, and research. The division also provides oversight of the state's correctional health care system. The Office of Data, Statistics and Vital Records (DSVR) provides technical assistance for the development, implementation, and evaluation of data collection activities. DSVR has an FTE to oversee data collection and analysis activities for the MCH block grant. DSVR maintains the vital records system for the state including births, deaths, marriages, divorces, and fetal deaths and issues certified copies of such records. The State Public Health Laboratory provides testing, consultation, and expert testimony in support of local, state and federal agencies and the general public.

The Division of Health Systems Development and Regulation administers regulatory programs related to health protection and health care facilities including the traditional public health areas of sanitation and safety, inspection and licensure of public facilities and Medicaid/Medicare survey and certification of health care facilities and providers. The Office of Rural Health (ORH) works to improve the delivery of health services to rural/medically underserved communities with an emphasis on access including recruitment of health professionals, technical assistance to health care facilities, development and use of telemedicine applications, and oversight of the South Dakota Trauma System. The Office of Public Health Preparedness and Response directs the state's bioterrorism/public health emergency response efforts. Past DOH preparedness funding has been used to strengthen the public health infrastructure in South Dakota including improvements in communication and computer systems for MCH field staff.

A copy of applicable DOH organizational charts are provided as an attachment to this section.

An attachment is included in this section.

D. Other MCH Capacity

Preventive and primary care services to the MCH population are provided through OFCH. OFCH provides direction to state-employed nurses, nutrition educators, and dietitians for the provision of public health services in the state. Field staff providing primary preventive services for mothers, infants, and children include 6.3 FTE for mothers and infants and 8.8 FTE for children and adolescents. Another 8.3 FTE provide family planning services in the state.

OFCH and OHP central office program staff dedicated to providing program direction to specific MCH program areas include: 1.39 FTE for child and adolescent health; 0.63 FTE for perinatal health; 2.2 FTE for family planning services; and 3.68 FTE for CSHS.

Darlene Bergeleen, RN, is the administrator of OFCH and serves as the MCH Program Administrator. Darlene has been with the DOH for 37 years and has served as the administrator of the former Office of Community Health Services for 10 years. Darlene has been actively involved in MCH block grant services in her years in the Office of Community Health and assumed the position of MCH Program Administrator in January 2010. Barb Hemmelman is the MCH Program Coordinator and serves as the CSHS Program Coordinator. Barb has been with the DOH since September 2004 and previously worked as the Director of the state's early intervention program within DOE Office of Special Education. Everett Putnam serves as the MCH State Data Contact and has been with the DOH since December 1988. Other MCH team members include the following:

- Linda Ahrendt , Administrator, Office of Health Promotion
- Kristin Biskeborn, State Nutritionist
- Rhonda Buntrock, WIC Program Administrator
- Terry Disburg, Sexual Violence Prevention Coordinator
- Bev Duffel, SDFP Program Administrator
- Julie Ellingson, Oral Health Coordinator
- Lucy Fossen, Newborn Metabolic/Hearing Screening Coordinator
- Lon Kightlinger, State Epidemiologist
- Jim McCord, Tobacco Control Program Administrator
- Anthony Nelson, Administrator, Office of Data, Statistics, and Vital Records
- Josie Peterson, Office of Rural Health
- Colleen Reinert, Coordinated School Health Coordinator
- Peggy Seurer, Perinatal Nursing Consultant
- Susan Sporrer, Division of Administration
- Nato Tarkhashvilii, Epidemiologist
- Kelli Westley, Breastfeeding Coordinator

- Jenny Williams, Child and Adolescent Health Coordinator/CSHS Consultant
- Vacant, Chronic Disease Epidemiologist

Parent Connection identifies and recruits parents of CYSHCN to provide mentoring and peer support to other families with CYSHCN. They provide a family perspective to CSHS program staff regarding programs, policies and procedures, maintain a statewide database of support parents and groups, provide parent-to-parent training, and link parents throughout the state with trained supporting parents in a community-based manner. The MCH Program Coordinator serves on the advisory panel to assist in ongoing collaboration opportunities.

E. State Agency Coordination

South Dakota's public health system includes the DOH, community health centers (CHCs), IHS, and tribal health representatives. While many states use local health departments to deliver public health services, in South Dakota these services are delivered by the DOH and funded primarily with federal or state resources. There is only one local health department in the state located in Sioux Falls. However, it primarily focuses on environmental health issues.

Representatives from the DOH and the Community HealthCare Association of the Dakotas (CHAD) continually explore ways to increase collaboration and coordination of health services such as MCH, family planning, community health, and infectious disease control. In some areas, DOH staff are co-located with CHCs. Where feasible, local DOH staff meet regularly with CHC staff to address identified needs and facilitate the development of a seamless system of care.

IHS delivers services to the American Indian population on the state's nine reservations. There are IHS hospitals in Eagle Butte, Pine Ridge, Rapid City, Rosebud, and Sisseton. On many of the reservations, tribally-appointed community health representatives also provide services.

The DOH is a member of the South Dakota Kids Cabinet. The Kids Cabinet is authorized through a Governor's Executive Order and is comprised of Governor's Cabinet members and one designee from the DOH, DSS, DHS, DOE, and the Department of Corrections. The mission of the Kids Cabinet is to maximize communication, collaboration, and cooperation among departments of state government serving children and their families and to improve the quality, quantity, and coordination of service delivery processes, programs, and systems. Key outcomes identified by the Kids Cabinet include: (1) children and youth remain at home with their families or within their communities whenever possible; (2) children enter school eager and ready to learn; and (3) children and youth are physically and mentally healthy. In addition to initiatives specific to early childhood education, youth in state custody, and development of systems of care for youth with serious emotional disturbances and their families, the Kids Cabinet has prioritized initiatives to decrease disparities in health, education, and social services for American Indian children and youth.

The DOH and DSS have an interagency agreement to establish and assure referral mechanisms between agencies. The intent of the agreement is to maximize utilization of services and assure that services provided under Title V and Title XIX are consistent with the needs of recipients and that the objectives and requirements of the two programs are met. The agreement establishes procedures for early identification and referral of individuals under age 21 in need of services such as EPSDT, family planning, case management, and WIC. Representatives from both agencies meet regularly to discuss various issues including care coordination of high-risk pregnant women, referral mechanisms, outreach for Medicaid, and SCHIP.

The DOH has a number of information and referral mechanisms to assist in the identification and enrollment of eligible children for Medicaid services such as WIC, CSHS, CHNs, and PHA. WIC facilitates referrals and links applicants with services so that families can access Medicaid as well as other health and social programs. In addition to the State program, there are three tribally-

operated WIC programs on the Cheyenne River, Rosebud and Standing Rock Indian reservations. Coordination between the WIC and Medicaid program occurs as all Medicaid eligibility approvals of pregnant women are automatically reported to the WIC program on a weekly basis. CHN/PHA staff serve as an information and referral source to inform families of Medicaid availability and facilitate enrollment in Medicaid by referral. CSHS financial assistance process requires the family to also apply to Medicaid to ensure they are accessing all services that can be of assistance.

In CY 09, SDFP provided services to 2,858 adolescents under the age of 19. Of these, 1,083 were between the ages of 15-17; 10,063 of SDFP clients were females. In 2007, SDFP received funding to integrate HIV testing and prevention activities in family planning clinics. In CY 2006 (prior to the funding), 200 HIV tests were provided. In CY 2009, 1,596 HIV tests were provided. The goal is to assure everyone is aware of his or her HIV status as part of routine preventive care. For the past three years, special funding has been available to increase the number of family planning users. As a result of this funding, Sanford Downtown Healthcare in Sioux Falls has seen a 19.5% increase in the number of adolescent users and a 30% increase in the number of women under 150% of the FPL from 2008 to 2009. The Community Health Center of the Black Hills saw a 21% increase in the number of adolescent users and a 5% increase in the number of low income clients.

In 2003, the South Dakota Legislature passed a concurrent resolution supporting the creation of a South Dakota plan for suicide prevention. The resolution recognized that suicide is a significant problem in South Dakota and declared that prevention of suicide be made a state priority by strengthening the private and public entities charged with addressing the problem. The overarching goals of the suicide plan include: (1) implementation of effective, research-based suicide prevention programs to reach the public and at-risk populations (i.e., elderly, American Indians, youth/young adults, and rural communities); (2) provision of guidelines to schools for the development of effective suicide prevention programs; (3) development of public information campaigns designed to increase public knowledge of suicide prevention; (4) work with postsecondary institutions to develop effective clinical and professional education on suicide; (5) assurance that schools have effective linkages with mental health and substance abuse services; and (6) implementation of effective, comprehensive support programs for survivors of suicide.

The DOH collaborates with DHS to address issues affecting children and adolescents and their families such as suicide, tobacco use, FASD, and HIV prevention. DOH staff provide assistance and representation on the Division of Alcohol and Drug Abuse Advisory Council for Safe and Drug-Free Schools application reviews, Developmental Disabilities Council, and FASD Task Force.

DHS administers the state's Respite Care Program. The program is jointly funded with state general funds, MCH block grant funds, and some DSS federal grant funds. The Respite Care program offers services statewide. MCH block grant funds are expended to provide services for children on the program diagnosed with chronic medical conditions. CSHS program staff assist families with referral to the Respite Care Program. The program has an advisory group with representation from various state programs serving families who have children with special needs including special education, child protection, developmental disabilities, mental health, and CYSHCN. Parents are also represented on this group.

DOH is involved in an interagency agreement with DOE, DHS, and DSS to ensure collaboration in the maintenance and implementation of a statewide, comprehensive, coordinated, multidisciplinary, and interagency service delivery system for children eligible under Part C of the Individuals with Disabilities Education Act (IDEA). This system is designed to ensure the availability and accessibility of early intervention services for all eligible infants and toddlers and their families. This agreement outlines the roles and responsibilities of the participating agencies related to the specific services required and provides guidance for their implementation.

South Dakota receives competitive grant funding from CDC for coordinated school health programming. Funding supports a collaborative relationship between the DOE and DOH in efforts to help local schools implement and coordinate school health programs directed towards the CDC priority areas of nutrition, physical activity, tobacco, and HIV. DOE and DOH have a Memorandum of Agreement outlining the responsibility and requirements to implement the program and have developed a very effective relationship that allows for maximum use of finances, staffing and resources. CSHP collaborates with the Department of Game, Fish and Parks (GFP) to offer the "Fantastic Field Trips" to teachers at no cost. Each teacher receives a packet of information including core content-based lessons and physical activity options while visiting the park. CSHP has provided funding to GFP to purchase snowshoes to enhance physical activity of youth and their families through the use of equipment that entices people to be more physically active.

South Dakota Schools Walk was started in 2003 in partnership between DOH and DOE to encourage students to become more physically active to help combat childhood obesity. Schools Walk is open to children of all ages but students in grades K-6 are eligible to receive incentives for their participation. South Dakota Schools Walk is a variation of the CDC program in that it focuses not only on kids walking/biking to school, but also kids walking while they are at school and for those attending After School Time Programs. The DOH continues to offer mini-grants to schools to support activities to improve nutrition and increase physical activity. These grants allow schools to use creative methods to address obesity in youth. In 2009-2010, South Dakota Schools Walk involved 4,276 K-6 grade students and 181 staff while the Schools Walk After School Program involved 810 K-6 grade students and 41 staff.

In 2004, Delta Dental of South Dakota partnered with Ronald McDonald House Charities to create the Ronald McDonald Care Mobile program in South Dakota. Delta Dental was granted a Ronald McDonald Care Mobile van with two fully equipped dental operatories to travel statewide to increase access to dental care in underserved areas of South Dakota. The strong demand for the Care Mobile prompted Delta Dental to expand the mobile dental program with the addition of a second truck -- the Smile Mobile -- utilizing funds from the John T. Vucurevich Foundation. Both the Care Mobile and the Smile Mobile operate under the program name "Delta Dental's Dakota Smiles Mobile Dental Program". The mission of the Dakota Smiles program is to treat children without access to dental care, which includes those children ages 0-21 who have not seen a dentist within the past two year and/or those that live more than 85 miles from a dentist. No child is turned away for inability to pay. Dental services provided include teeth cleaning, fillings for cavities, tooth extractions, dental sealants, fluoride treatments, instructions on care of teeth/gums, and tobacco/smoking cessation counseling. The Dakota Smiles program works with local site partners/sponsors who pay a site partner fee of $2,500 per week and who have the ability to identify and recruit patients who would otherwise have difficulty accessing dental services. Examples of past site partners have been Head Start agencies, Boys & Girls Clubs, United Way, Kiwanis, CHCs, hospitals, churches, local social services agencies, local service clubs, and schools. The care mobile typically spends a week in each community. The addition of a second unit enables the program to provide care for adults as well.

Since September 2004, the Dakota Smiles Mobile Dental Program has visited 65 communities across the state and served 11,388 children. Of those children, 50% were Medicaid/SCHIP enrolled and 43% were uninsured. To date, 67,430 diagnostic and preventive procedures and 21,645 restorative procedures have been completed. The retail dollar value of care provided is nearly $5 million. As a key partner with Delta Dental, the DOH has committed to staffing and coordinating services, as well as allocating resources to aid in providing oral health education, immunizations, and assistance in maintaining a referral system for patients of the Dakota Smiles program. Providing primary dental care to children in these remote areas emphasizes the importance of preventive measures such as early intervention and continuing oral health education.

The DOH has a long-standing collaborative relationship with the Center for Disabilities within the

USD School of Medicine's Department of Pediatrics. The South Dakota Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disorders (LEND) is a program of the Center for Disabilities that works to improve the health status of infants, children, and adolescents with neurodevelopmental and related disabilities. The LEND program provides one year of specialized training focusing on the interdisciplinary training of professionals for leadership roles in the provision of health and related services to infants, children and adolescents with neurodevelopmental and related disabilities and their families. The program augments graduate studies in the disciplines of audiology, health administration, medicine, nursing, nutrition, speech-language pathology, occupational/physical therapy, pediatric dentistry, psychology, and public health social work. In addition to LEND, MCH and the Center for Disabilities collaborate on a number of training and other interagency projects.

In April 2008, DSS was awarded over $7.6 million in grant funds from the Centers for Medicare and Medicaid Services (CMS) to provide health care services in non-emergency room settings. South Dakota was one of 20 states to receive federal funding, receiving the largest award of all states and having the most projects funded. Projects supported by the grant are located in Martin, Mission, Pine Ridge, Wagner, Sioux Falls, and other South Dakota locations. The project focus is on providing access to non-emergency care to improve health outcomes and decrease the use of costly hospital emergency rooms. Grant funds are supporting health care staff recruitment, extended clinic hours, enhanced technology to link professionals to isolated communities, health education, chronic disease management clinics, and school-based health care services. Through the grant, a mobile medical clinic was built for the Pine Ridge Reservation. The mobile clinic provides a medical home for pregnant women and children up to age 21 on the Pine Ridge Reservation. The mobile clinic was used during H1N1 efforts to provide immunizations in communities on the Pine Ridge Reservation.

MCH staff also serve on a variety of workgroups and advisory boards including Highway Safety Workgroup, Oral Health Advisory Board, Coordinated School Health Workgroup, Healthy South Dakota Workgroup, State Diabetes Coalition, Parent Connection Family to Family Advisory Council, Early Intervention Coordinating Council, and Interagency Council on Homelessness.

F. Health Systems Capacity Indicators

Introduction

As was noted earlier, the MCH program works collaboratively with partners throughout the year on programs and strategies to improve the health of women, infants, children, adolescents, and CYSHCN. While specific activities/strategies and data interpretation information is provided under each individual Health Systems Capacity Indicator, one initiative of the MCH program this past year focused on the development of the "I Didn't Know My Weight Matters" media campaign to increase awareness of the importance of appropriate weight gain during pregnancy.

The MCH program utilizes State Systems Development Initiative (SSDI) funds to access community hospital discharge data from the South Dakota Association of Healthcare Organizations (SDAHO) to address MCH performance measures. In addition, SSDI funds are used to conduct the Perinatal Health Risk Assessment Survey of new mothers to obtain data on behaviors and care/education received prior to, during and post pregnancy. Data collected via the survey are used to address MCH performance measures.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	17.0	19.7	18.8	18.4	15.9

Numerator	89	103	103	104	95
Denominator	52218	52218	54828	56450	59640
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Association of Healthcare Organizations hospital discharge data. Rate based on 2009 South Dakota population estimate and 2009 community hospital discharges only.

Notes - 2008
2007 South Dakota Association of Healthcare Organizations hospital discharge data. Rate based on 2007 South Dakota population estimate and 2007 community hospital discharges only.

Notes - 2007
2006 South Dakota Association of Health Care Organizations hospital discharge data. Rate based on 2006 South Dakota population estimate and 2007 community hospital discharges only.

Narrative:
The DOH uses SSDI funds to maintain the established access to hospital discharge data collected by SDAHO. The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age shows an almost flat trend. While the rates fluctuate over the years, none of the years are significantly different from the other years. The data for this measure comes from SDAHO hospital discharge data which does not include IHS data.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	86.3	87.7	84.7	82.7	78.6
Numerator	5182	5334	5504	5225	4965
Denominator	6008	6079	6501	6319	6319
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Department of Social Services Medicaid data

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Narrative:
Data is received from the DSS Medicaid office. CHN offices providing MCH services collaborate with the WIC and Immunization programs to identify children in need of referral for an initial or periodic screen. Ages and Stages developmental questionnaires are provided to parents periodically to assess their child's developmental stages.

The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one periodic screen shows a slight downward trend. While the rates fluctuate over the years, 2005 is not significantly different from 2006 and 2007 but 2006 is significantly different from all year except 2005. 2008 and 2009 are significantly different from the other years.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	91.1	84.6	82.9	79.0
Numerator	135	123	104	92	94
Denominator	135	135	123	111	119
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Department of Social Services Medicaid data

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Narrative:
Data is received from the DSS Medicaid office. CHN offices providing MCH services collaborate with the WIC and Immunization programs to identify children in need of referral for an initial or periodic screen. Ages and Stages developmental questionnaires are provided to parents periodically to assess their child's developmental stages. The percent SCHIP enrollees whose age is less than one year during the reporting year who received at least one periodic screen shows a downward trend.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	77.9	72.1	73.5	73.9	74.8
Numerator	8798	8434	8849	8749	8795

Denominator	11288	11695	12039	11834	11754
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota birth certificate data

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data

Narrative:
The DOH Baby Care, Bright Start Nurse Home Visiting Program, Family Planning, and WIC programs strongly encourage pregnant women to seek early and regular prenatal care. Surveys of mothers conducted by the DOH have indicated the main reasons women didn't receive prenatal care in the first trimester is they were waiting to qualify for Medicaid or they didn't know they were pregnant.

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index shows a slight downward trend. While the rates fluctuate over the years, 2005 is significantly different from the other years and the 2006 rate is also significantly different from all years except 2007. Caution should be used in interpreting this data due to a change in the birth certificate structure and the way these data are collected. The initiation of prenatal care for the 2006 and later data are determined using date last normal menses began and date of first prenatal care visit. Data for 2005 used the month prenatal care began provided on the birth certificate.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	80.0	79.5	81.4	82.3	83.4
Numerator	78906	79423	81319	83033	85813
Denominator	98633	99903	99903	100902	102920
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Department of Social Services Medicaid data

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Narrative:
Data is received from DSS Medicaid Office. DOH collaborates with DSS to assure Medicaid/ SCHIP information and application forms are available at all DOH field offices for clients who may be eligible. There is also a link to the Medicaid website from the DOH website. All potentially eligible clients who received WIC, Baby Care, or CSHS services are asked to apply for Medicaid. Staff assist in completing the process as needed. The percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program shows a slight upward trend. While the rates fluctuate over the years, all years are significantly different.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	35.9	39.7	38.8	45.2	48.9
Numerator	7268	8211	8093	9733	11008
Denominator	20225	20661	20880	21526	22498
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Department of Social Services Medicaid data

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Narrative:
DOH collaborates with partners in the Oral Health Coalition to assure families who are eligible for Medicaid/SCHIP are aware they are eligible for dental services. The DOH has provided training to WIC and CHN staff on oral health including discussions regarding Medicaid eligibility and access to care for Medicaid/SCHIP clients. Efforts continue to collaborate with CSHP to inform school nurses of oral health programs and initiatives through newsletters, School Nurse Notes, and participation in annual conferences.

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year shows an upward trend. Even though the percentages fluctuate between years, only 2006 and 2007 are not significantly different than other years. In 2006, Delta Dental

helped two large Head Start programs with mandatory dental screenings and fluoride varnish applications. The DOH helped them establish relationships with providers to do the screenings and the Head Start nurses are now doing the fluoride varnishes. Most of the dentists in the community are now doing the screenings for free or the funding is coming from the Head Start budget. The 2008 increase may also be attributed to at least one of the following: (1) the addition of a second mobile dental care unit; (2) SDDA emphasis on fluoride treatments for kids, (3) large spike in January 2008 for a couple of dentists doing fluoride varnishes (many of the patients would have had to been new/first time patients for that kind of spike); (4) CHCs may be seeing more patients; and (5) new dentists beginning practice who accept Medicaid patients. Delta Dental reports the total child patients grew by over 15% between from 2007 to 2008.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	46.3	34.7	36.5	29.1	
Numerator	757	605	677	557	
Denominator	1636	1746	1857	1916	2023
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Since July 1, 2008, the South Dakota Children Special Health Services program does not directly provide rehabilitative service to state SSI beneficiaries. 2009 denominator data are from the Social Security Administration.

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Narrative:
The DOH collaborates with the Social Security Administration (SSA) and DHS programs serving children with chronic medical conditions, severe emotional disorders or developmental disabilities and promotes outreach and access to rehabilitative services, mental health services, medical care, and service coordination. An ongoing joint powers agreement between DOH, DHS and SSA assures that SSI child beneficiaries and potential beneficiaries under the age of 18 are provided appropriate outreach, referral, disability determination, and rehabilitation services. Due to changes in the CYSHCN program, the program no longer directly provides rehabilitative services to state SSI eligible children and therefor this data is not available.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**		
Comparison of health			**MEDICAID**	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of low birth weight (< 2,500 grams)	2009	payment source from birth certificate	6.7	5.4	5.9

Narrative:
Data is received from DSVR and Medicaid. Through the DOH Baby Care and Bright Start Nurse Home Visiting programs, pregnant women are provided information on warning signs of preterm labor. Staff have been advised by several women that they have not received this information from their health care provider, but through the education provided by Baby Care and Bright Start they were able to identify signs and symptoms or preterm labor and seek appropriate medical attention. The percent of low birth weight babies increased across all populations. The small numbers tend to produce rates with more variability than larger numbers due to chance variations.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2009	payment source from birth certificate	7.8	6.1	6.7

Narrative:
Data is received from DSVR and Medicaid. The state's infant mortality rate has increased resulting in concerns as to the potential causes. In 2006, the DOH convened a workgroup to look at issues surrounding infant mortality. The workgroup reviewed data and found infant death is more common among mothers who received no prenatal care, smoked during pregnancy, were younger than 19 years of age, had not finished high school, were American Indian, and lived in a "frontier" county. As a result of the findings, the workgroup identified six key activities to reduce the state's infant mortality rate. The DOH 2020 Initiative goal is to reduce the state's infant mortality rate to 6.0 infant deaths per 1,000 live births by 2020.

The Medicaid population infant deaths per 1,000 live births shows an upward trend. While the percents fluctuate over the years, none of the years are statistically different. The numbers used to calculate these rates are relatively small and tend to yield wider confidence intervals than larger numbers would produce. The non-Medicaid population infant deaths per 1,000 live births shows a downward trend, however none of the years are statistically different. When comparing the percents between the Medicaid and non-Medicaid populations for each year, only the 2008 percents are significantly difference. The total population infant deaths per 1,000 live births shows an almost flat trend. While the percents fluctuate slightly over the years, none of the years are significantly different.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	payment source from birth certificate	54.5	71.9	65.7

Narrative:
The DOH Baby Care, Bright Start Nurse Home Visiting program, Family Planning, and WIC programs strongly encourage pregnant women to seek early and regular prenatal care. A survey of mothers conducted by the DOH indicate the main reasons women did not receive prenatal care in the first trimester was they were waiting to qualify for Medicaid or they didn't know they were pregnant.

Both the Medicaid and non-Medicaid population percent of infants born to pregnant women receiving prenatal care beginning in the first trimester shows a downward trend. When comparing the percents between the Medicaid and non-Medicaid populations for each year, all years are significantly different. The total population percent of infants born to pregnant women receiving prenatal care beginning in the first trimester shows an almost flat trend. While the percents fluctuate over the years, only the 2005 and 2009 percents are significantly different from the other years. Caution should be used in interpreting this data due to a change in the birth certificate structure and the way these data are collected. The initiation of prenatal care for the 2006 and later data are determined using date last normal menses began and date of first prenatal care visit. Data for 2005 used the month prenatal care began provided on the birth certificate.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	payment source from birth certificate	70	77.5	74.8

Narrative:
Data regarding entry into prenatal care is retrieved from the birth certificate. Information regarding barriers to access is obtained through questions on the Perinatal Health Risk Assessment Survey. All women of childbearing age accessing services within CHN offices are strongly

encouraged to obtain early and regular prenatal care. Through case management services for pregnant women, appointments with prenatal care providers are facilitated.

The Medicaid population percent of pregnant women with adequate prenatal care (observed to expected prenatal visits greater or equal to 80% [Kotelchuck Index]), shows a downward trend. While the percents fluctuate over the years, only 2005 is significantly different from the other years and 2006 is significantly different from 2008 and 2009. The non-Medicaid population percent of pregnant women with adequate prenatal care (observed to expected prenatal visits greater or equal to 80% [Kotelchuck Index]), shows an almost flat trend. While the percents fluctuate over the years, none of the years are significantly different. When comparing the percents between the Medicaid and non-Medicaid population for each of the given years, only the 2005 percents are significantly different. The total population percent of pregnant women with adequate prenatal care (observed to expected prenatal visits greater or equal to 80% [Kotelchuck Index]), shows an almost flat trend. While the percents fluctuate over the years, the 2005 percent is significantly different from other years and 2006 is significantly different from 2008 and 2009. Caution should be used in interpreting this data due to a change in the birth certificate structure and the way these data are collected. The initiation of prenatal care for the 2006 and later data are determined using date last normal menses began and date of first prenatal care visit. Data for 2005 used the month prenatal care began provided on the birth certificate.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	140
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
DOH programs, including the MCH programs and WIC, routinely identify and refer uninsured infants to the Medicaid/SCHIP programs for financial assistance for medical care.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	140
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children	2009	

(Age range 1 to 19) (Age range to) (Age range to)		200

Narrative:
DOH programs, including the MCH programs and WIC, routinely identify and refer uninsured infants to the Medicaid/SCHIP programs for financial assistance for medical care.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	

Notes - 2011
Pregnant women are not eligible for SCHIP

Narrative:
Some pregnant women are eligible to receive full Medical Assistance while other pregnant women are only eligible for pregnancy-related services. DOH programs, including the MCH programs and WIC, routinely identify and refer uninsured pregnant women to the Medicaid program for financial assistance for medical care.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn	3	Yes

screening files		
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Key MCH program staff have direct access, with security blocks as needed, to information on infant birth certificates, WIC files, metabolic files, and Perinatal Health Risk Assessment Survey data. This access allows the MCH program to obtain data as needed for program policy and planning. Additional information is available upon request from Medicaid to match to birth certificate data. Under a contract with SDAHO, hospital discharge data is received from all community hospitals in South Dakota. IHS and Veterans Administration hospitals do not report data.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
BRFSS	3	Yes

Notes - 2011

Narrative:
The TCP coordinates tobacco control activities within the DOH. TCP staff participate in MCH team meetings to communicate activity and progress. The TCP collaborates with DOE to collect tobacco usage data through the Youth Risk Behavior Survey (YRBS) which is repeated every two years in South Dakota. The survey was administered to students in the spring of 2009.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The DOH priority needs are based on the needs assessment completed for the FY 2011-2015 needs assessment cycle. The South Dakota MCH five-year needs assessment provides an overview of the status of the priorities established by the MCH program as required by the Title V MCH Block Grant program. Priority needs in South Dakota cross the four levels of the public health services pyramid. The following priority needs in South Dakota cross the four levels of the public health services pyramid and are measured through both national and state performance measures:

• Reduce unintended pregnancies;
• Improve pregnancy outcomes;
• Reduce infant mortality;
• Reduce morbidity and mortality among children and adolescents;
• Improve adolescent health and reduce risk-taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization);
• Reduce childhood obesity;
• Improve the health of, and services for, children with special health care needs (CSHCN) through comprehensive services and support;
• Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN; and
• Improve state and local surveillance and data collection and evaluation capacity.

The priority setting process is an ongoing and evolving process. Systems development for women, infants, children, adolescents, and CSHCN is an integral part of the MCH planning process and includes analyzing current programs and services, identifying gaps in services, establishing appropriate goals and objectives, collaborating with partners, and establishing methods for monitoring and evaluating programs and services to ensure that goals and objectives are met.

The MCH team also initiated a MCH Assessment, Planning and Monitoring Process which is data driven, with the starting point of assessing the needs of the MCH population groups using Title V health status and system capacity indicators, performance measures, and other quantitative and qualitative data. The process focused on needs, priorities, targets, and activities -- not specific programs or individuals. The team discussed national and state performance measures, determining if objectives were met or unmet. Health system capacity, health status indicators, and data sets used were analyzed. Additional data sources to assist in assessment of each population group were identified. As a result of this process, state performance measures were identified. The MCH program utilized focus groups to gather additional input.

B. State Priorities

As a result of the MCH assessment, South Dakota has developed eight performance measures that relate directly to identified priority needs. Priority needs in South Dakota, as well as the respective performance measures and activities that address these needs, cross the four levels of the core public health infrastructure pyramid -- direct services, enabling services, population-based services, and infrastructure building services.

Direct service interventions improve health status and reduce adverse outcomes. Since enabling services facilitate and enhance direct services, activities in both levels of the pyramid will address the state's priorities. There are several priority needs that primarily impact the population-based service level. In order to accomplish improvement in the state's priorities, there must be education and service interventions at both the direct and enabling service levels. Conversely, effective

interventions at the direct and enabling service levels require population-based education and other activities. All state priority needs have elements of infrastructure building services. The development of an interagency collaborative infrastructure is critical to reducing barriers to care and improving health outcomes. Improved state and local surveillance, data collection and evaluation capacity facilitate data-driven decision making regarding allocation or resources and strategies to address the priority needs. Coordination, quality assurance, standards development, and monitoring must accompany interventions to reduce barriers to care and improve and assure appropriate access to health services focused on families, women, infants, children, adolescents, and CYSHCN.

For the 2011-2015 needs assessment cycle, South Dakota has selected the following state performance measures:

SPM #1: Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.
Unintended pregnancies are associated with maternal health risk behaviors, low use of preventive health measures (i.e., early prenatal care), child abuse, and dependency on welfare. There is a greater risk for complications and poor pregnancy outcomes including infant mortality, birth defects, and low birth weight infants.

SPM #2: Percent of singleton birth mothers who achieve a recommended weight gain during pregnancy.
Gestational weight gain is an important determinant of fetal growth. Inadequate weight gain increases risk of inadequate fetal growth, low birth weight, and infant death. Excessive weight gain increases risk of excessive fetal growth leading to increased incidence of C-section. Risk of maternal complications such as hypertension are also increased. Maternal weight gain is susceptible to intervention and represents an avenue for prevention of poor birth outcomes. A woman with a normal BMI should gain 29 to 40 pounds; and those with a high BMI should gain 15 to 25 pounds. Excessive weight gain also is often retained by the mother thus contributing to adult obesity and high BMI for subsequent pregnancies.

SPM #3: Percent of pregnant women aged 18-24 who smoked during pregnancy.
Smoking during pregnancy is estimated to account for 20 to 30 percent of low birth weight babies and about 10 percent of all infant deaths. Smoking during pregnancy can cause the baby to have more colds, lung problems, learning disabilities, and physical growth problems.

SPM #4: Percent of infants exposed to secondhand smoke.
Infants exposed to secondhand smoke are at increased risk for developing respiratory infections, allergies, asthma, digestive difficulties, and SIDS.

SPM #5: Percent of WIC infants breastfed at 6 months of age.
Both babies and mothers gain benefits from breastfeeding. Breast milk is easy to digest and contains antibodies that can protect infants from bacterial and viral infections. In addition, research suggests breastfeeding decreases obesity in childhood and later in life.

SPM #6: Percent of school-aged children and adolescents with a Body Mass Index (BMI) at or above the 95th percentile.
Obesity is a risk factor for many chronic medical conditions including cardiovascular disease, hypertension, diabetes, degenerative joint disease, and psychological problems. Overweight can result from excessive energy intake, decreased energy expenditure, or impaired regulation of energy metabolism.

SPM #7: Percent of high school youth who self-report tobacco use in the past 30 days.
Smoking is responsible for one in six adult deaths in the U.S. and is the single most preventable cause of death.

SPM #8: Accidental death rate among adolescents aged 15-19 year old.
South Dakota's teen accidental death rate is almost double the national average. The leading causes of accidental deaths -- motor vehicle crashes and suicide -- can both be prevented.

South Dakota's State Outcome Measure addresses the American Indian infant mortality rate for the state. The infant mortality rate is a traditional indicator of general health status. American Indian infant mortality has been a long standing public health problem. Using a five-year rolling average, the discrepancy in American Indian and white infant mortality has decreased over the past five years from 2.7 in 2004 to 2.2 in 2009 while overall infant mortality rates for the state have decreased from 8.2 to 6.7.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	5	8	11	14	18
Denominator	5	8	11	14	18
Data Source				Metabolic Screening Program	Metabolic Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
2007-2009 South Dakota Metabolic Screening Program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.

Notes - 2008
2006-2008 South Dakota Metabolic Screening Program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.

Notes - 2007
2005-2007 South Dakota Metabolic Screening Program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.

a. Last Year's Accomplishments

• Partnered with the University of Iowa Hygienic Laboratory (UHL) for the provision of newborn metabolic screening laboratory services in South Dakota for all mandated disorders including congenital hypothyroidism, galactosemia, PKU, hemoglobinopathies, biotinidase deficiency, congenital adrenal hyperplasia, amino acid disorders, fatty acid oxidation disorders, organic acidemias, and cystic fibrosis.

• Updated information links and resources on the DOH Newborn Screening website.

• Provided educational materials to birth hospitals regarding newborn screening specimen collection and submission to UHL.

•Collaborated with laboratory and health care providers to assure follow-up on infants with indeterminate or abnormal specimens.

• Provided follow-up to those infants without metabolic screening results through ongoing matching of birth certificates and laboratory reports.

• Collaborated with DSVR to link birth and death certificates with the laboratory results through EVRSS for data collection and monitoring.

• Distributed brochure explaining Newborn Screening to hospitals, physicians, and other health care providers in the state.

• Expanded LTFU program to include all children residing in South Dakota identified with biotinidase deficiency, hemoglobinopathies, congenital adrenal hyperplasia, amino acid disorders, fatty acid oxidation disorders, organic acidemias, galactosemia, PKU, and congenital hypothyroidism.

• Sent quality assurance reports to submitting facilities comparing unacceptable specimen rates and turnaround times with State averages.

• Collaborated with the Regional Genetics and Newborn Screening Collaborative to identify the regional needs of improving access to newborn screening services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain/improve newborn metabolic screening data collection system.				X
2. Screen/provide necessary follow-up for required disorders.			X	
3. Verify notification of indeterminate and abnormal test results.	X			
4. Distribute newborn metabolic screening program brochure to healthcare providers.			X	
5. Link birth/death certificates with newborn screening laboratory results through EVRSS.				X
6. Update program manual as necessary and distribute to hospitals and healthcare providers in the state.				X
7. Maintain and update newborn screening program website.				X
8. Refer infants diagnosed with a metabolic disorder to CSHCN program.			X	
9. Collaborate with UHL to provide technical assistance to				X

facilities and healthcare providers as need is identified.				
10. Expand LTFU program for children residing in South Dakota identified with a metabolic disorder.			X	

b. Current Activities

• Providing ongoing technical assistance to hospitals/physician offices regarding process changes in newborn screening procedures with UHL.

• Collaborating with UHL and health care providers to assure follow-up on infants with indeterminate or abnormal specimens.

• Providing follow-up to those infants without metabolic screening results through ongoing matching of birth certificates and laboratory reports.

• Collaborating with DSVR to link birth certificates with the laboratory results through the EVRSS for data collection and monitoring.

• Strengthening relationships with medical specialists in South Dakota to assure appropriate follow-up and medical management for infants with positive screening results.

• Utilizing the UHL website to monitor indicators of quality such as turnaround times and poor quality specimen.

• Collaborating with the Regional Genetics and Newborn Screening Collaborative to identify the regional needs of improving access to newborn screening services.

• Updating information links and resources on the DOH Newborn Screening website.

c. Plan for the Coming Year

• Partner with UHL for the provision of newborn metabolic screening laboratory services in South Dakota for all mandated disorders.

• Initiate RFP process to contract for state newborn screening laboratory services.

• Update information links and resources on the DOH Newborn Screening website.

• Offer ongoing technical assistance to hospitals and physician offices regarding newborn screening.

• Collaborate with contract laboratory and health care providers to assure follow-up on infants with indeterminate or abnormal specimens.

• Provide follow-up to those infants without metabolic screening results through ongoing matching of birth certificates and laboratory reports.

• Collaborate with DSVR to link birth certificates with the laboratory results through the EVRSS for data collection and monitoring.

• Distribute brochure explaining Newborn Screening to hospitals, physicians, and other health care providers in the state.

• Continue to strengthen relationships with medical specialists in South Dakota to assure appropriate follow-up and medical management for infants with positive screening results.

•Monitor indicators of quality such as turnaround times and poor quality specimen through utilization of the UHL website.

• Collaborate with the Regional Genetics and Newborn Screening Collaborative Region V to identify the regional needs of improving access to newborn screening services.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**12481**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)		0.0				
Congenital Hypothyroidism (Classical)	12430	99.6	8	10	10	100.0
Galactosemia (Classical)	12430	99.6	3	0	0	
Sickle Cell Disease	12430	99.6	6	2	2	100.0
Biotinidase Deficiency	12430	99.6	8	0	0	
Cystic Fibrosis	12430	99.6	18	2	2	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	12430	99.6	29	0	0	
Amino Acid and Acylcarnitine	12430	99.6	203	10	10	100.0
PKU	0	0.0	0	20	18	90.0
Congenital Hypothyroidism	0	0.0	0	63	60	95.2
Galactosemia	0	0.0	0	3	3	100.0
Amino Acid and Acylcarnitine	0	0.0	0	27	27	100.0
Sickle Cell Disease/Hemoglobinopathies	0	0.0	0	7	7	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	96	96	98.5	97
Annual Indicator	96.0	96.0	98.5	96.4	97.8
Numerator	452	452	15977	15950	12826

Denominator	471	471	16226	16554	13114
Data Source				BRFSS	BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97.8	97.8	98	98.5	98.5

Notes - 2009
2009 South Dakota BRFSS survey weighted data

Notes - 2008
2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of those respondents indicating they had a CSHCN, 96.4% reported they were satisfied with the involvement you have had with your child's health care team in making decisions about what care is provided to your child.

Notes - 2007
2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN, 98.5% reported they were satisfied with the involvement you have had with your child's health care team in making decisions about what care is provided to your child.

a. Last Year's Accomplishments
• Shared resources for families including support groups and transition planning resources.

• Collaborated with South Dakota Parent Connection (SDPC) (South Dakota's Parent Training Center) who provides information, resources, and individual assistance and training (via DDN, webinar, and in-person workshops) to teach and empower families to partner with professionals to ensure child and family needs are met to their satisfaction. From June 1, 2009 through November 30, 2009, SDPC served over 488 families from across South Dakota. SDPC is the sole distributor of the FILE record keeting system for families of CSNCH with over 5,000 FILES distributed. Families receive FILES directly from SDPC or via SDPC partnerships with the early intervention program, family support providers, and NICU staff at the three largest hospitals in the state.

• Shared training/conference opportunities with families and children that give families opportunities to meet other families in similar situations and identify ways to access different resources/programs such as the annual Dare to Dream Conference.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate on activities to support/empower parents.		X		

2. Identify training opportunities for families.		X		
3. Request public input prior to any administrative rules revisions impacting child/family involvement in the CSHS program.				X
4. Expand long-term follow-up program			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Identifying and sharing new resources for families including support groups and transition planning resources.

• Collaborating with SDPC on parent training opportunities, FILE record system, Family to Family contacts, and other activities to support families.

• Sharing training/conference opportunities with families and children that give families opportunities to meet other families in similar situations and identify ways to access different resources/programs such as the annual Dare to Dream Conference.

• Strengthening relationships with medical specialists in South Dakota to assure appropriate follow-up and medical management for infants with positive newborn metabolic screening results.

• Expanding LTFU program to include all children residing in South Dakota identified with biotinidase deficiency, hemoglobinopathies, congenital adrenal hyperplasia, amino acid disorders, fatty acid oxidation disorders, organic acidemias, galactosemia, PKU, and congenital hypothyroidism.

• Representing DOH on various advisory councils that assist families in accessing services including the state's early intervention program, Diabetes Coalition, and Developmental Disabilities Council.

c. Plan for the Coming Year

• Work with SDPC to cross-train their staff and CSHS staff on opportunities each program offers to improve and maintain the training and systems-building component of each program.

• Promote community training opportunities for families and providers on decision making and medical/home partnerships.

• Serve as an ad hoc member of the Family to Family Advisory Committee.

• Continue LTFU program and have annual contact with parents/caregivers to assess their needs as well as with primary care providers and/or specialty physician to ensure ongoing care.

• Collaborate with community programs to identify available community resources for families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	84	91	91	97.3	97.3
Annual Indicator	90.8	90.8	97.3	97.3	96.7
Numerator	345	345	16631	14820	11476
Denominator	380	380	17099	15226	11869
Data Source				BRFSS	BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97.4	97.4	97.5	97.5	97.5

Notes - 2009
2009 South Dakota BRFSS survey weighted data.

Notes - 2008
2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of those respondents indicating they had a CSHCN and who had a primary doctor working with them to identify and assess the medical and non-medical needs to help the child and family achieve their goals, 97.3% rated the communication between the child's primary doctor and other health care provider as good, very good, or communication not needed.

Notes - 2007
2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN and who had a primary doctor working with them to identify and assess the medical and non-medical needs to help the child and family achieve their goals, 97.3% rated the communication between the child's primary doctor and other health care provider as good, very good, or communication not needed.

a. Last Year's Accomplishments
• Networked with providers and families to address services and assistance available under CSHS.

• Provided care coordination and financial assistance to children with chronic medical conditions and their families through CSHS.

• Collaborated with SDPC who provided individual assistance to families of CSHCN to connect them to medical and dental services/supports, distribution of informational materials, and electronic distribution of information and resources via SDPC website and publications. SDPC provided information sessions to social workers, case managers, and NICU staff at the state's the three largest hospitals on SDPC services and resources available to families of CSHCN. Similar sessions were also provided at Children's Care Hospital and School, SD March of Dimes, and SD Council of Mental Health Centers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide care coordination services to children with chronic medical conditions.		X		
2. Network with providers and families on provision of services.				X
3. Provide financial assistance for medical and mileage expenses to ensure comprehensive care.		X		
4. Collaborate with SDPC				X
5. Expand LTFU program			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Providing e-mail address for families to access assistance via the internet and enhancing www.children.sd.gov website to include application package.

• Contracting for care coordinator positions to assist families in receiving coordinated, comprehensive care.

• Networking with providers and families to address services and assistance available under CSHS.

• Continuing collaborative efforts with SDPC.

• Strengthening relationships with medical specialists in South Dakota to assure appropriate follow-up and medical management for infants with positive newborn metabolic screening results.

• Expanding LTFU program to include all children residing in South Dakota identified with biotinidase deficiency, hemoglobinopathies, congenital adrenal hyperplasia, amino acid disorders, fatty acid oxidation disorders, organic acidemias, galactosemia, PKU, and congenital hypothyroidism.

• Representing DOH on various advisory councils that assist families access services including the state's early intervention program, Diabetes Coalition, and Developmental Disabilities Council.

c. Plan for the Coming Year

• Provide financial assistance for medical and mileage expenses to appointments to ensure ongoing, comprehensive care.

• Provide care coordination services to children with chronic medical conditions.

• Network with providers and families to address services and assistance available under CSHS.

• Maintain e-mail access and website.

• Continue LTFU program and have annual contact with parents/caregivers to assess their needs

as well as with primary care providers and/or specialty physicians to ensure ongoing care.

• Collaborate with community programs to identify available community resources for families.

• Maintain DOH representation on various advisory councils that assist families access services.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	69	69	89.7	91
Annual Indicator	69.2	69.2	89.6	91.0	91.4
Numerator	326	326	16040	16622	13484
Denominator	471	471	17900	18267	14749
Data Source				BRFSS	BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	91.5	91.5	91.5	91.5	91.5

Notes - 2009
2009 South Dakota BRFSS survey weighted data.

Notes - 2008
2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of those respondents indicating they had a CSHCN, 91% reported they felt they had adequate health insurance.

Notes - 2007
2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN, 89.6% reported they felt they had adequate health insurance.

a. Last Year's Accomplishments
• Assisted in identification and referral of CSHCN and their families and facilitated application to Medicaid, SCHIP, and SSI as appropriate.

• Provided care coordination and financial assistance to children with chronic medical conditions and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide financial assistance for services for CSHCN.		X		
2. Assist in the identification and referral of CSHCN and their families and facilitate their application to Medicaid, SCHIP, and SSI.		X		
3. Identify new assistance programs available for families.				X
4. Collaborate with SDPC				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Providing financial assistance for services for CSHCN up to 250% of FPL and no cost share with all eligible families receiving 100% coverage after all other third party payers.

• Assisting in identification and referral of CSHCN and their families and facilitating application to Medicaid, SCHIP, and SSI as appropriate. CSHS requires all families applying for financial assistance to first apply to Medicaid which has resulted in more families accessing Medicaid assistance.

• Linking families to other resources that can assist with needs not being met by their public or private health care coverage (i.e., prescription assistance, community-specific assistance programs).

• Ensuring staff are aware of assistance programs available to families such as the SD Risk Pool (insurance for individuals who have lost insurance coverage through no fault of their own), Respite Care Program, Family Support Services, and Birth to 3 Connections (early intervention program).

• Collaborating with SDPC who provides individual assistance to families of CSHCN and professionals serving this population to provide information to link families to financial support programs such as Medicaid, SCHIP, SSI, Health KiCC, Family Support 360, Shriners, and others. SDPC distributes hundreds of program brochures each year and regularly features information and updates on these and many other related programs via SDPC website and publications.

c. Plan for the Coming Year

• Collaborate with DHS and SSA to facilitate action on transmittals from Disability Determination Services.

• Collaborate with DHS (Divisions of Mental Health, Developmental Disabilities, and Vocational Rehabilitation), SSA, DSS (Medicaid and SCHIP), and DOE (Birth to 3) to assist in the provision of coverage and services for CSHCN.

• Identify possible assistance programs/resources available across the state.

• Continue collaborative activities with SDPC.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	76	76	76	88.3	94.3
Annual Indicator	74.6	74.6	88.0	94.3	92.9
Numerator	343	343	13496	14097	10625
Denominator	460	460	15333	14955	11433
Data Source				BRFSS	BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94.5	94.5	94.5	94.5	94.5

Notes - 2009
2009 South Dakota BRFSS survey weighted data.

Notes - 2008
2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of those respondents indicating they had a CSHCN, 94.3% reported community-based services used were organized and easy to use "sometimes" or "always".

Notes - 2007
2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN, 88.1% reported community-based services used were organized and easy to use "sometimes" or "always".

a. Last Year's Accomplishments
• Provided care coordination and financial assistance to children with chronic medical conditions and their families through CSHS.

• Received referrals from physicians, schools, parents, hospitals, and other agencies.

• Assisted in the provision of needed services for specialty care and/or primary care follow-up for CSHCN in their home community.

• Contracted for the provision of genetic outreach services in two locations in the state.

• Collaborated with SDPC who contracts with five regional/reservation coordinators and 15 trained Peer Navigators across the state to deliver services to families and communities. SDPC

developed an early intervention video to increase awareness of the program and aid in early identification.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to improve coordination of care for CSHCN.				X
2. Continue networking efforts to ensure awareness of CSHS.				X
3. Provide care coordination services to children with chronic medical conditions.		X		
4. Contract for genetics outreach clinics.	X			
5. Collaborate with SDPC				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Improving coordination of care by establishing linkages with other agencies, programs, and providers via conferences, task forces, workgroups, and program planning committees.

• Providing care coordination, clinical services, and/or financial assistance to children with chronic medical conditions and their families through CSHS.

• Receiving referrals from physicians, schools, parents, hospitals, and other agencies.

• Assisting in the provision of needed services for specialty care and/or primary care follow-up for CSHCN in their home community.

• Providing e-mail address for families to access assistance via the internet and enhancing www.children.sd.gov website to include application package.

• Collaborating with SDPC who provided individual assistance and training to families and Head Start providers on Pine Ridge, Rosebud, and Cheyenne River Tribal Reservations.

• Expanding LTFU program to include all children residing in South Dakota identified with biotinidase deficiencies, hemoglobinopathies, congenital adrenal hyperplasia, amino acid disorders, fatty acid oxidation disorders, organic acidemias, galactosemia, PKU, and congenital hypothyroidism.

• Representing DOH on various advisory councils that assist families access services including the state's early intervention program, Diabetes Coalition, and Developmental Disabilities Council.

• Contracting for the provision of genetic outreach services in two locations in the state.

c. Plan for the Coming Year

• Develop and implement new media strategies to address CSHS changes including increased financial assistance with family income now up to 250% of FPL and no cost share.

• Communicate with all medical providers so they are aware of CSHS program and the services/assistance available to their patients.

• Continue to collaborate with SDPC.

• Reemphasize the role of the primary care provider in the care of the CSHCN population regarding the medical home, coordination of care, and needed communication between all providers.

• Maintain e-mail access and website.

• Continue LTFU program and have annual contact with parents/caregivers to assess their needs as well as with primary care providers and/or specialty physicians to ensure ongoing care.

• Collaborate with community programs to identify available community resources for families.

• Maintain DOH representation on various advisory councils that assist families access services.

• Expand contract for genetics outreach services to three locations.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	55	55	86.2	86.9
Annual Indicator	53.5	53.5	86.2	86.9	96.2
Numerator	69	69	5434	4202	4408
Denominator	129	129	6307	4836	4584
Data Source				BRFSS	BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	96.2	96.2	96.2	96.2	96.2

Notes - 2009
2009 South Dakota BRFSS survey weighted data.

Notes - 2008
2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of

those respondents indicating they had a CSHCN, 86.9% reported the services their child 12-17 years of age received helped them transition to adult health care, work, and independence.

Notes - 2007
2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN, 86.2% reported the services their child 12-17 years of age received helped them transition to adult health care, work, and independence.

a. Last Year's Accomplishments
• Provided care coordination and financial assistance to children with chronic medical conditions and their families through CSHS.

• Collaborated with SDPC staff who serve on various boards and committees that address transition issues such as the SD Board of Vocational Rehabilitation and the Sioux Falls Area Interagency Transition Council.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist adolescent CSHCN identify/address needs related to transition to adult life.		X		
2. Collaborate with SDPC				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Assisting adolescent CSHCN and their families prior to age 18 identify areas of need related to transition to all aspects of adult life through care coordination activities and resource identification. The CSHS program works with CSHCN and their families up to the child's 21st birthday.

• Representing the DOH on various advisory councils that assist families access services including the state's early intervention program, Diabetes Coalition, and Developmental Disabilities Council.

• Collaborating with SDPC, DOE Special Education Services, and Healthy and Ready to Work National Resource Center to deliver two free statewide webinars specific to healthcare transition to adulthood in March and April 2010. One webinar was directed towards educators, transition specialists, and school nurses. A second session was directed towards parents and youth.

c. Plan for the Coming Year
• Provide financial assistance under CSHS with family income up to 250% of FPL with no cost share.

• Identify additional training and resources to assist adolescents and their families in planning for

their adult care.

• Maintain DOH representation on various advisory committees that assist families access services.

• Collaborate with SDPC who will be working with the Center for Disabilities to host a free summer transition training series for families of CSHCN across the state in 2010 via either DDN or webinars.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84	85	86	75	86
Annual Indicator	72.8	72.8	74.9	78.9	73.1
Numerator	10811	11626	11798	9802	9180
Denominator	14856	15967	15742	12430	12558
Data Source				SD Immunization Information System	SD Immunization Information System data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	77	79	81	83

Notes - 2009
2009 South Dakota Immunization Information System data

Notes - 2008
2008 South Dakota Immunization Information System data

Notes - 2007
2007 South Dakota Immunization Information System data

a. Last Year's Accomplishments
• Purchased Varicella vaccine; 2nd dose is required for school entry.

• Served as a "universal-select" vaccine provider to distribute federally-funded vaccine free of charge.

• Offered free HPV vaccine to all females 12 years of age and VFC-eligible females age 11-18 years.

• Offered Menactra to underinsured children age 11-18 years through CHN sites which are designated as rural health clinics.

• Provided influenza vaccine for children aged 6 months through 18 years.

• Offered schools, university/colleges, tribal colleges, and Head Starts access to SDIIS.

• Distributed immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.

• Accessed immunization status of infants and children served by TANF and Medicaid, those receiving home visits through Bright Start, and those receiving services through the Dakota Smiles Mobile Dental Program.

• Developed/refined local agency plans to improve the assessment, administration, and referral for immunizations.

• Provided technical assistance and resources to seven active immunization coalitions.

• Conducted annual audits on immunization records for all kindergarten and transfer students.

• Offered immunization incentives to vaccine providers, parents, and children.

• Expanded communication with vaccine providers and offered training for new and existing vaccine providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue as "universal-select" vaccine provider and distribute federally-funded vaccine.			X	
2. Promote childhood immunizations.			X	
3. Purchase Hepatitis A vaccine to be available to all children 1-18 years of age.			X	
4. Offering Menactra to underinsured children (11-18 years old through OCHS sites which are designated as rural health clinics.			X	
5. Partnering with major health systems to provide H1N1 vaccination to children.			X	
6. Promote the birth dose of Hepatitis B vaccine.			X	
7. Collaborate with DSS to assess immunization status of children receiving public assistance.				X
8. Promote immunization data entry into SDIIS.				X
9. Provide support and resources to community immunization coalitions.				X
10. Add immunization materials to the Bright Start Welcome Box.			X	

b. Current Activities

• Purchasing Varicella and influenza vaccine.

• Serving as "universal-select" vaccine provider to distribute federally-funded vaccine free of

charge.

• Offering Menactra to underinsured children age 11-18 years through OCHS sites designated as rural health clinics.

• Providing seasonal/H1N1 influenza vaccinations for children age 6 months through 18 years.

• Partnering with major health care systems to offer H1N1 vaccine to children through schools and community clinics.

• Encouraging enrollment in SDIIS for South Dakota birthing hospitals to promote birth dose of Hepatitis B.

• Offering schools, universities/colleges, and Head Starts access to SDIIS.

• Distributing immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.

• Accessing immunization status of infants and children served by TANF, Medicaid, Bright Start home visit program, and Dakota Smiles Mobile Dental Program.

• Developing/refining local agency plans to improve the assessment, administration, and referral for immunizations which focuses on the WIC/immunization linkage and any infant/child seeking services in DOH field offices.

• Providing technical assistance and resources to seven active immunization coalitions.

• Conducting annual audits on immunization records for all kindergarten and transfer students.

• Expanding communication with vaccine providers and offering training for new and existing vaccine providers.

c. Plan for the Coming Year

• Continue as a "universal-select" vaccine provider and distribute federally-funded vaccine free of charge through ODP.

• Purchase Varicella and influenza vaccine.

• Serve on local community immunization workgroups to assess immunization needs and facilitate development of plans to immunize children.

• Encourage Immunization Program enrollment for all South Dakota birthing hospitals to promote the birth dose of Hepatitis B.

• Distribute immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.

• Access immunization status of infants and children served by TANF and Medicaid, those receiving home visits through Bright Start, and those receiving services through the Dakota Smiles Mobile Dental Program.

• Continue to develop and refine local agency plans to improve assessment, administration, and referral for immunizations. The local plan focuses on the WIC/Immunization linkage and any infant/child seeking services through OCHS/PHA offices.

• Collaborate with DSS to include immunization information to the Bright Start Welcome Boxes.

• Provide technical assistance and resources to seven active local community immunization coalitions.

• Conduct annual audits of immunization records for all kindergarten and transfer students.

• Promote immunization data entry into SDIIS.

• Offer training for new and existing vaccine providers.

• Maintain Blast Fax and Listserv to communicate with vaccine providers.

• Create a data warehouse for SDIIS which will allow ad hoc reporting and a mobile application to allow access from smart phone devices.

• Finalize HL7 connection between SDIIS and the IHS system and begin work on HL7 connection between SDIIS and electronic health records.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	19	18	18	19
Annual Indicator	19.8	18.7	19.8	20.8	18.5
Numerator	337	318	334	345	303
Denominator	16982	16982	16828	16591	16406
Data Source				Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	18.5	18.5	18	18	18

Notes - 2009
2009 South Dakota birth certificate data. Rate based on 2009 South Dakota population estimate.

Notes - 2008
2008 South Dakota birth certificate data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota birth certificate data. Rate based on 2006 South Dakota population estimate. In analyzing the trend of increasing birth rate for teenagers aged 15-17 years, the rate was compared for Native Americans and Whites. The birth rate for Native American teens remains greater than for Whites. The number of births to Native American teenagers is approximately the

same while the total number of White teenagers is 6 times the total number of Native American teenagers. In analyzing the rates by these two races, it is apparent there is an increasing trend for both races but the increase is greater for Native Americans. In 2003 the rate for Native Americans was 55.0 births per 1,000 female teenagers and in 2007 this has increased to 62 births. This compares to a rate of 8.7 births per 1,000 White female teenagers in 2003 increasing to 11.7 in 2007. While services area available on four of the nine reservations and through Urban Indian Health in Aberdeen, Pierre, and Sioux Falls, very few Native American teenagers access family planning services through South Dakota Family Planning. The Family Planning Program has submitted a grant application to fund new partnerships on the Pine Ridge and Standing Rock Reservations.

a. Last Year's Accomplishments

• Provided family planning services to 2,858 adolescents age 19 and under during CY09; approximately 41.8% of adolescents seen were 17 years of age or younger.

• Provided community/school education services related to reproductive health to 4,727 adolescents in CY09.

• Provided community/school abstinence education programs to 4,347 individual, primarily students under age 19 from October 2008 through June 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Negotiate new/monitor existing contracts for the provision of abstinence education.				X
2. Provide reproductive health services to adolescents.			X	
3. Provide community/school education programs related to reproductive health upon request.			X	
4. Collaborate with community-based organizations to identify new strategies to reduce the rate of births for adolescents.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Providing family planning services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.

• Providing community/school education services related to reproductive health upon request to adolescents.

c. Plan for the Coming Year

• Provide family planning services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.

• Provide community/school education services related to reproductive health upon request to

adolescents.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	55	55	61.5	61.5
Annual Indicator	49.4	61.1	61.1	61.1	61.1
Numerator	351	392	392	392	392
Denominator	710	642	642	642	642
Data Source				SD Oral Health Survey	SD Oral Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	61.5	62	62	62	62

Notes - 2009
2006 South Dakota oral health survey data

Notes - 2008
2006 South Dakota oral health survey data.

Notes - 2007
2006 South Dakota oral health survey data.

39% of children in the 2006 oral health survey did not have dental sealants. In 2006, 61% of the 3rd grade children screened had dental sealants compared to 50% in 2003. 70% of American Indian children had dental sealants in 2006. During the last three years, the prevalence of dental sealants has increased dramatically in South Dakota. These comparisons indicate a significant improvement in the percentage of children with dental sealants.

The small numbers tend to produce rates with more variability than larger numbers due to chance variations. No adjustments will be made in the Annual Performance Objective until the next oral health survey to determine if a definite trend can be identified.

a. Last Year's Accomplishments
• Provided educational materials and resources on oral health through dental clinics, DOH offices, Head Start/Early Head Start, FQHCs, health fairs, professional meetings/conferences, etc.

• Participated on the Oral Health Coalition Steering Committee and subcommittees.

• Facilitated oral health education/training opportunities for staff with DOH, CHCs, Head Starts, day cares, and other health providers.

• Continued discussions with Delta Dental, SDDA, and ORH regarding options for improving access to oral health care for South Dakota children.

• Partnered with Delta Dental on the Dakota Smiles project to provide educational materials for their dental patients and families.

• Served on Advisory Board for the Partner for Prevention project to address oral health training for non-dental health professionals.

• Developed and distributed brochure about the hazards of consuming sweetened beverages.

• Partnered with Oral Health Coalition to air oral health messages on tv/radio statewide including messages specifically targeting the American Indian population.

• Partnered with DSS to provide oral health information in the Bright Start Welcome Box.

• Provided oral health information for the CSHP electronic newsletter "NewsInfused".

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide "train the trainer" oral health education to Head Start/Early Head Start staff, day care providers, DOH regional managers, and CHNs.				X
2. Conduct Basic Screening Survey of 3rd grade students in randomly selected schools.			X	
3. Update the DOH oral health webpage as needed.				X
4. Partner with ORH to conduct community dental needs assessments for the Dental Tuition Reimbursement Program.				X
5. Serve on the advisory board for the Dakota Smiles Mobile Dental Program.				X
6. Provide oral health brochure in Bright Start Welcome Box.			X	
7. Participate on Oral Health Coalition Steering Committee and subcommittees.				X
8. Distribute oral health resource materials for health care providers and child advocates at various health events, conferences, association meetings, health fairs, etc.			X	
9. Partner with Delta Dental to provide oral health resources for patients served by the Dakota Smiles Program.				X
10. Collaborate with AATCHB oral health program staff to provide oral health resources for the American Indian population.				X

b. Current Activities

• Participating on the Oral Health Coalition steering committee.

• Facilitating oral health education/training opportunities and resources for DOH, CHCs, Head Starts/Early Head Start, day cares, and other health providers.

• Discussing options with Medicaid, Delta Dental, SDDA, and ORH for improving access to oral health care for children.

• Updating DOH oral health website as needed.

• Partnering with ORH to conduct community dental needs assessments for the Dental Tuition Reimbursement Program.

• Participating on Advisory Board for the Dakota Smiles Mobile Dental Program and providing financial support for the mobile clinics.

• Providing "train the trainer" oral health materials for DOH regional managers and CHNs.

• Collaborating with IHS and AATCHB to distribute oral health resources to the American Indian population.

• Partnering with DSS to provide oral health information in the Bright Start Welcome Box.

• Providing oral health information for "NewsInfused".

• Exploring conducting a dental assessment of Head Start children.

• Contracting with regional dental hygienists to provide oral health education to local MCH populations and tobacco cessation training for dental professionals.

• Conducting Basic Screening Survey (BSS) of 3rd grade students in selected schools.

c. Plan for the Coming Year

• Participate on the Oral Health Coalition steering committee.

• Facilitate oral health education/training opportunities to update staff with DOH, CHCs, Head Starts, day cares, and other health providers.

• Continue discussions with Medicaid, Delta Dental, SDDA, and ORH regarding options for improving access to oral health care for children in South Dakota.

• Updating DOH oral health website as needed.

• Partner with ORH to conduct community dental needs assessments for the Dental Tuition Reimbursement Program.

• Provide educational materials and resources on oral health through dental clinics, DOH offices, Head Start/Early Head Start, FQHCs, health fairs, day care providers, professional meetings/conferences, etc.

• Participate on Advisory Board for the Dakota Smiles Mobile Dental Program and provide financial support for the mobile clinics; provide oral health educational materials for distribution to Dakota Smiles patients and their families.

• Contract with Delta Dental to fund the Dakota Smile sealant program and site partner fees for American Indian communities.

• Provide "train the trainer" oral health materials for DOH regional managers and CHNs.

• Collaborate with IHS and AATCHB to distribute oral health resources to the American Indian population in South Dakota.

• Partner with DSS to provide oral health information in the Bright Start Welcome Box.

• Provide oral health information for "NewsInfused".

• Develop and disseminate report of BSS of 3rd grade students.

• Contract with USD to conduct sealant programs and preventive interventions for underserved populations.

• Contract with Sisseton-Wahpeton Oyate to enhance their Cavity Free by 2-0-1-3 program.

• Contract with SDDA to provide oral health training and resources for medical professionals, including OB/GYNs.

• Partner with schools on a pilot project to include oral health programs in school-based health clinics.

• Provide oral health resources for distribution, including the recently developed pregnancy/oral health brochure and the sweetened beverage posters.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	9.5	5.1	3
Annual Indicator	10.3	7.1	5.1	3.1	4.3
Numerator	16	11	8	5	7
Denominator	155916	155916	156390	161819	163841
Data Source				Death Certificate	Death Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	3	3	3	3

Notes - 2009
2007-2009 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2007-2009 South Dakota population estimates.

Notes - 2008
2006-2008 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2006-2008 South Dakota population estimates.

Notes - 2007

2005-2007 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2004-2006 South Dakota population estimates.

a. Last Year's Accomplishments

• Promoted community awareness campaigns designed to increase seat belt use.

• Attended the fourth annual South Dakota Safety Conference to promote roadway safety.

• Participated in quarterly Roadway Safety Committee meetings to discuss highway safety priorities, active state/local projects, and opportunities for partnership.

• Promoted "Parents Matter" campaign which promotes anti-drinking and driving with youth across the state.

• Collaborated with DSS on the Project 8 Program which provides a coordinated statewide system of child safety seat education and inspection in South Dakota; 5,044 car seats were distributed to eligible families along with instructions on proper installation techniques; 3,088 additional car seats were inspected of which 88% were installed incorrectly; 119 public education events were held reaching 8,167 individuals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with local advocates, law enforcement, and emergency responders statewide to enhance public awareness and promote the use of seatbelts.			X	
2. Participate in Roadway Safety Committee to improve roadway safety.				X
3. Collaborate with prevention agencies to address underage drinking and impaired driving.				X
4. Promote the Project 8 Program which provides a coordinated statewide system of child safety seat education and inspection.			X	
5. Promote the Safe Routes to Schools Program which provides funding to school districts to improve safety concerns for children walking and biking to school.			X	
6. Explore opportunities with the SD Department of Transportation on the Driver Education Research Project to describe current driver education programs, recommend curriculum and teacher certification requirements, and assess effectiveness of the progra				X
7.				
8.				
9.				
10.				

b. Current Activities

• Providing training for elementary and middle school teachers on the LifeSkills curriculum which provides education on alcohol, tobacco, and other drugs as well as healthy life choices.
• Promoting seatbelts and anti-drinking and driving through statewide media campaigns.
• Participating on Roadway Safety Committee which meets quarterly to discuss roadway safety issues including drivers' education, drunk driving prevention, and motorcycle safety.
• Supporting Safe Ride Program which promotes anti-drinking and driving in four South Dakota

communities.

c. Plan for the Coming Year

• Support Parents Matter campaign which promotes anti-drinking and driving in numerous school systems and communities in the state.

• Support statewide high visibility enforcement campaigns promoting seat belt use.

• Promote the Project 8 Program.

• Participate in quarterly Roadway Safety Committee meetings to discuss information about highway safety priorities, active state and local projects, and opportunities for partnerships.

• Support Safe Routes to Schools program which provides funding to schools to increase safety of children walking or biking to school.

• Support Driver Education Research Project to identify/recommend the most effective driver education programs for young drivers.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		43	43	44	44
Annual Indicator	34.7	38.8	40.5	41.8	47.5
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	47.5	47.5	48	48	48

Notes - 2009
2009 National Immunization Survey (NIS) data. Numerator and denominator are not available.

Notes - 2008
2008 National Immunization Survey (NIS) data. Numerator and denominator are not available.

Notes - 2007

2007 National Immunization Survey data. Numerator and denominator are not available.

The percentage of mothers who breastfeed their infants at 6 months of age shows upward trend. Even though none of the years are significantly different, data still indicates an upward trend in the percent of breastfeeding.

a. Last Year's Accomplishments

• Participated on the South Dakota Breastfeeding Coalition to promote World Breastfeeding Week and obtained a Governor's proclamation for World Breastfeeding Week.

• Educated mothers in the Bright Start nurse home visiting, WIC, and Baby Care programs on the benefits of breastfeeding and provided support and encouragement to initiate and continue breastfeeding.

• Provided information to health professionals, hospitals, work sites, and public promoting breastfeeding through the Breastfeeding Peer Counselor Program.

• Provided updated breastfeeding information on the DOH and HealthySD.gov websites.

• Collaborated with WIC to develop, purchase, and distribute materials for World Breastfeeding Week and ongoing marketing of breastfeeding.

• Partnered with the Nutrition and Physical Activity program to provide resources to prenatal/breastfeeding educators to improve breastfeeding rates as well as highlighting breastfeeding on the HealthySD.gov website and promoted two brochures on returning to work and breastfeeding.

• Participated in the development of Breastfeeding and Child Care brochure and the development of the 2010 South Dakota Nutrition and Physical Activity State Plan.

• Implemented a Breastfeeding Peer Counselor Program in local WIC offices in Beadle, Butte, Charles Mix, Davison, and Roberts counties. The local programs received training on the peer counselor program and how they can work as a team to educate and support breastfeeding by WIC participants.

• Collected data on breastfeeding initiation rates for the state and by individual hospital; sent letters to hospitals with their individual rates and materials on how to increase and support breastfeeding.

• Offered breastfeeding classes to WIC clients at local agencies and collaborated with hospitals, clinics, and community resources to refer WIC clients to breastfeeding classes when not available in office.

• Loaned electric breast pumps to MCH and WIC clients to encourage continued breastfeeding; provided program participants with manual breast pumps as needed.

• Distributed bimonthly WIC Wellness Nutrition Fun Facts newsletter to WIC participants containing breastfeeding educational materials.

• Developed and implemented a statewide plan to improve breastfeeding rates through the state plan breastfeeding goals and objectives.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Participate on the South Dakota Breastfeeding Coalition.				X
2. Educate mothers in various DOH programs on the benefits of breastfeeding and provide support/encouragement to initiate and continue breastfeeding.			X	
3. Provide information to health professionals, hospitals, worksites, and public promoting breastfeeding.				X
4. Update breastfeeding information on healthysd.gov and DOH websites.				X
5. Develop, purchase, and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.			X	
6. Promote continuation of breastfeeding to reduce overweight during childhood.				X
7. Address breastfeeding environment and support in communities.				X
8. Develop and implement a statewide plan to improve breastfeeding rates.				X
9.				
10.				

b. Current Activities

• Participating on the South Dakota Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion.

• Providing education and support to mothers in the Bright Start nurse home visiting, WIC, and Baby Care programs to encourage continued breastfeeding.

• Providing information to health professionals, hospitals, work sites, and the public promoting breastfeeding.

• Updating breastfeeding information on the DOH and healthysd.gov websites to promote breastfeeding.

• Developing, purchasing, and distributing materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.

• Working to reduce barriers to breastfeeding, particularly in the workplace.

• Providing a Breastfeeding Peer Counselor Program to pregnant and breastfeeding WIC clients in Beadle, Butte, Davison, and Charles Mix counties to provide education and support breastfeeding.

• Developing local coalitions to address breastfeeding environment and support in communities as well as provide resources to educators of prenatal and breastfeeding classes.

• Developing and implementing a statewide plan to improve breastfeeding rates.

c. Plan for the Coming Year

• Develop and design a new WIC management information system to track and review breastfeeding initiation rates for WIC clients by local agency and statewide.

• Conduct survey of WIC clients to determine reasons why breastfeeding is not chosen as the preferred method for feeding infants.

• Expand Breastfeeding Peer Counselor Program.

• Conduct breastfeeding awareness activities.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	92	93	97.5	98
Annual Indicator	91.7	96.8	97.3	98.0	97.7
Numerator	10961	11992	12475	12374	12200
Denominator	11958	12386	12815	12631	12481
Data Source				Newborn Hearing Screening Program	Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	98	98	98

Notes - 2009
2009 South Dakota Newborn Hearing Screening Program data.

Notes - 2008
2008 South Dakota Newborn Hearing Screening Program data.

Notes - 2007
2007 South Dakota Newborn Hearing Screening Program data.

a. Last Year's Accomplishments
• Collaborated with hospitals to ensure all babies born in South Dakota are screened for hearing impairment before 1 month of age, evaluation from a diagnostic audiologist by 3 months of age (if needed), and intervention by 6 months of age (if needed).

•Provided training to hospitals receiving state-owned hearing screening equipment.

• Distributed educational materials regarding causes of infant hearing loss and language/hearing development milestones to appropriate facilities statewide.

• Collaborated with DSVR on EVRSS to successfully link birth records with infant hearing screening for all infants born in the state; EVRSS allows for tracking of these infants for follow-up, confirmatory testing, and treatment and is linked with hospitals, physician clinics, and audiologists

who provide follow-up and diagnostic services to the infants.

• Utilized Birth Certificate Worksheet to collect data on risk factors that may contribute to late-onset hearing loss.
• Exchanged hearing screening results for those infants born in South Dakota but who are residents of another state.

• Worked with the Early Head Start program to use hearing screeners to monitor, gather screening results, and provide follow-up for children served by Early Head Start.

• Conducted a statewide media campaign (i.e., tv, radio, newspaper, online) explaining 1-3-6 hearing screening process.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ensure infants receive timely hearing screening, evaluation, and intervention.			X	
2. Provide training for facilities with state-owned hearing screening equipment.				X
3. Distribute educational materials regarding causes of infant hearing loss and language/hearing development milestones to appropriate facilities.			X	
4. Collaborate with DSVR on EVRSS to link birth records with infant hearing screening data for all infants born in the state.				X
5. Utilize Birth Certificate Worksheet to collect data on risk factors that may contribute to late-onset hearing loss.				X
6. Work with other states to exchange hearing screening results.				X
7. Purchase/distribute hearing screeners and provide training for the Early Head Start program to screen those children they serve for hearing loss.				X
8.				
9.				
10.				

b. Current Activities
• Collaborating with facilities to ensure all babies born in South Dakota receive appropriate hearing screening, evaluation, and intervention.

• Exchanging results with other states for infants born in South Dakota but who are residents of another state.

• Utilizing Birth Certificate Worksheet to collect data on risk factors that may contribute to late-onset hearing loss.

• Providing training to hospitals receiving state-owned hearing screening equipment.

•Providing technical assistance to facilities on entering screening, rescreening, medical evaluation, and diagnostic audiological results into EVRSS.

• Providing educational materials in the Bright Start Welcome Box regarding late-onset hearing loss

• Updating the Newborn Hearing Screening website with current information.

• Collaborating with Early Head Start program to use hearing screeners gather and report screening results for children served by Early Head Start.

• Exploring feasibility of creating a tracking system within EVRSS for those infants identified through the Early Head Start Program.

c. Plan for the Coming Year

• Collaborate with facilities to ensure all babies born in South Dakota receive appropriate hearing screening, evaluation, and intervention.

• Work with other states to exchange results for infants born in South Dakota but who are residents of another state.

• Monitor and provide technical assistance on newborn hearing screening data entry into EVRSS.

• Provide training to and monitor hospitals receiving state-owned hearing screening equipment.

• Implement and monitor the tracking of infants with possible hearing loss with their screener, physician, diagnostic audiologist, and Birth to 3 program.

• Distribute Newborn Hearing Screening materials as requested.

• Explore creation of a tracking system for those infants identified through EVRSS as being a high risk for late-onset hearing loss.

• Work with pediatric audiologists in the state to improve EVRSS data entry of audiologic evaluations.

• Provide technical assistance to hospitals without protocols and procedures for infants who fail the hearing screening.

•Conduct outside evaluation of the newborn hearing screening program.

•Evaluate and enhance EVRSS to assist users and improve compliance with data entry.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4	3.3	3.2	2.7	2.7
Annual Indicator	3.3	3.2	2.8	2.9	2.1
Numerator	6213	6025	5451	5751	4192
Denominator	188270	188270	194681	198309	199616
Data Source				BRFSS	BRFS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.1	2.1	2.1	2.1	2.1

Notes - 2009
2009 South Dakota BRFSS survey weighted data. Rate based on 2009 South Dakota population estimate.

Notes - 2008
2008 South Dakota BRFSS survey weighted data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 BRFSS survey weighted data. Rate based on 2006 South Dakota population estimate.

a. Last Year's Accomplishments
• Collaborated with DSS to assure information regarding SCHIP and the expanded non-Medicaid SCHIP program was distributed to DOH staff and communities. Communication occurs at numerous levels including upper management.

• Provided SCHIP applications to families accessing DOH services and assisted in completion of forms as needed.

• Provided links to DSS Medicaid website from the DOH website.

• Required all clients requesting financial assistance with CSHS to first apply for Title XIX.

• Provided information regarding the South Dakota Risk Pool to families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure information regarding SCHIP is distributed to DOH staff and communities.				X
2. Provide SCHIP applications in DOH field offices and assist with completion of forms as needed.			X	
3. Provide links to DSS Medicaid website from DOH website.				X
4. Assure information regarding the South Dakota Risk Pool is available.				X
5. Work with families of adolescents that will be aging out of Medicaid to ensure they have considered future insurance coverage needs			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Collaborating with DSS to assure information regarding SCHIP and the expanded non-Medicaid SCHIP program is distributed to DOH staff and communities.

• Assuring families accessing DOH programs are provided information on available programs (i.e., SCHIP, Medicaid and Risk Pool).

• Identifying avenues to share information with families of adolescents who will be aging out of Medicaid at age 19 since they have many times not considered how they will cover their medical costs once they are no longer eligible. While CSHS can help with the cost of covered medical conditions, it can not cover acute illnesses and treatment for non-covered medical conditions.

c. Plan for the Coming Year

• Provide financial assistance under CSHS to families up to 250% of FPL with no cost share.

• Require all clients requesting financial assistance with CSHS to first apply for Title XIX.

• Provide information on the South Dakota Risk Pool to individuals who have lost their insurance coverage through no fault of their own and are unable to access different coverage.

• Identify avenues to share information on insurance planning for adolescents who will be aging out of Medicaid at age 19.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32	31	34	35
Annual Indicator	32.0	32.2	34.6	35.9	36.3
Numerator	2754	2649	2993	3276	3523
Denominator	8605	8228	8651	9125	9705
Data Source				PedNSS	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35	34	33	32	32

Notes - 2009
2009 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data.

Notes - 2008
2008 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data. As annual indicator continues to rise, the annual performance objectives for 2009-2013 were modified. The 2009 objective is expected to increase as new corrective measures will not be in place until later in the year.

Notes - 2007

2007 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data

a. Last Year's Accomplishments

• Collaborated with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases especially those objectives and strategies focused on parents and caregivers.

• Implemented the Fit from the Start initiative in registered childcare facilities which includes the Growing Healthy childcare curriculum for providers and parents.

• Provided educational information and materials to DOH staff and others for use with parents and childcare providers on how to increase physical activity for all ages of children including strategies to decrease TV viewing.

• Collaborated with partners to educate parents and childcare providers on the importance of good nutrition and physical activity for children and promoted Great Day of Play.

• Utilized healthysdgov and DOH websites to provide updated consumer and provider resources for overweight children and adolescents.

• Co-sponsored South Dakota State University (SDSU) Nutrition Seminar.

• Collaborated with GFP to offer physical activity and nutrition programming for families visiting state parks through recreation equipment, materials, and programs.

• Provided "Fruits and Veggies - More Matters" materials for parents to increase fruit and vegetable intake.

• Promoted National Turn of the TV Week in collaboration with program partners and HealthySD.gov.

• Implemented WIC food package which includes fresh fruits and vegetables, whole grains, and lower fat milk.

• Provided WIC Wellness Nutrition Fun Facts Newsletters to all WIC participants that includes recipes and physical education information.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner to provide nutrition and physical activity expertise in DOH.				X
2. Collaborate with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Disease and to develop a new 5 year plan.				X
3. Implement the new WIC food package to include fresh fruits and vegetables, whole grains, and lower fat milk; distribute "Get Healthy Now" kit to all 2-5 year old participants.			X	
4. Implement Fit from the Start Initiative in childcare facilities to increase access to vegetables, improve opportunities for physical activity, and decrease tv viewing for children 2-5 years of age.				X
5. Provide educational information and materials to DOH staff and others for use with parents and childcare providers on how			X	

to increase physical activity for all ages of children including strategies to decrease TV viewing.				
6. Collaborate with partners to educate parents and childcare providers on the importance of good nutrition and physical activity for children.			X	
7. Promote South Dakota Great Day of Play.			X	
8. Utilize the healthysd.gov and DOH websites to provide updated consumer and provider resources for overweight children and adolescents.			X	
9. Co-sponsor SDSU Nutrition seminar.			X	
10. Provide "Fruits and Veggies – More Matters" materials for parents to increase fruit and vegetable intake.			X	

b. Current Activities

• Providing nutrition and physical activity expertise to programs impacting preschool children.

• Collaborating with partners to implement objectives and activities in the State Plan to Prevent Obesity and Other Chronic Diseases focused on parents and caregivers.

• Providing media messages regarding healthy strategies to prevent obesity.

• Implementing Fit from the Start Initiative in childcare facilities to increase access to vegetables, improve opportunities for physical activity, and decrease tv viewing for children 2-5 years of age; trainers from Early Childhood Enrichment Centers, SDSU Cooperative Extension, and DOE food program sponsors providing training to providers to implement initiative.

• Providing materials to DOH staff and others on the importance of good nutrition and increasing physical activity for all ages of children including strategies to decrease tv viewing.

• Planning for fourth "SD Great Day of Play" in collaboration with the SD Park and Recreation Association to urge children, adults, and families to get outside and play or be physically active.

• Utilizing HealthySD.gov and DOH websites to provide updated consumer and provider resources for overweight children and adolescents.

• Co-sponsoring seminar on nutrition.

• Providing materials for parents on "Fruits & Veggies - More Matters".

• Implementing WIC food package.

• Providing WIC Wellness Nutrition Fun Facts newsletters to WIC participants that includes recipes and physical education information.

c. Plan for the Coming Year

• Provide educational information and materials to DOH staff and interested parties for use with parents and others who serve preschool children on how to increase physical activity and healthy eating, especially fruits and vegetables, for all ages of children.

• Implement 2010 State Plan to Prevent Obesity and Other Chronic Diseases.

• Work with partners to educate parents on the importance of good nutrition and physical activity for their children.

• Utilize DOH and HealthySD.gov websites to provided updated consumer and provider resources for overweight children and adolescents.

• Collaborate with GFP to offer physical activity and nutrition programming for families visiting state parks through recreation equipment, materials, and programs.

• Collaborate with SD Park and Recreation Association and GFP to conduct "South Dakota Great Day of Play".

• Promote National Turn Off the TV Week to include activities targeting the pre-school population.

• Modify Fit from the Start Initiative based on evaluation and continue to implement in child care facilities.

• Implement new WIC food package.

• Collaborate with partners to explore better ways to educate parents about nutrition and physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		10	14	14	13
Annual Indicator		14.0	14.2	13.0	12.9
Numerator		1645	1707	1545	1520
Denominator		11722	12061	11859	11775
Data Source				Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12.9	12.9	12.8	12.8	12.8

Notes - 2009
2009 South Dakota birth certificate data

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data. The percentage of women who smoke in the last three months of pregnancy shows a slight increase over 2006 but no difference statistically. Due to the fact that only two years of data are available, no trend can be determined at this time.

a. Last Year's Accomplishments

• Risk assessed pregnant clients and provided tobacco cessation/referral services to clients.

• Promoted South Dakota QuitLine to assist pregnant women quit using tobacco.

• Provided training to professionals about the risks associated with smoking during pregnancy.

• Contracted with Northern Plains Healthy Start to support direct service operations.

• Provided tobacco prevention materials in Bright Start Welcome Boxes to reinforce the message of not smoking during future pregnancies and preventing second hand smoke exposure for infants and young children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Risk assess all pregnant women seeking services at DOH offices for smoking status three months prior to pregnancy as well as current smoking status.			X	
2. Provide education, informational materials, and referrals to encourage and assist with smoking cessation.		X		
3. Collaborate with a variety of organizations to educate professionals about the risks associated with smoking during pregnancy.				X
4. Contract with Northern Plains Healthy Start to support direct service operations.				X
5. Collaborate with Healthy Start to collect data on smoking and the correlation between smoking and premature birth and low birth weight infants born to clients they serve.				X
6. Collaborate with DSS to include tobacco prevention materials and incentives in the Bright Start Welcome Boxes.			X	
7.				
8.				
9.				
10.				

b. Current Activities

• Risk assessing pregnant clients and providing tobacco cessation/referral services to clients.

• Promoting South Dakota QuitLine to assist pregnant women quit using tobacco.

• Providing training to professionals about the risks associated with smoking during pregnancy.

• Contracting with Northern Plains Healthy Start to support direct service operations on reservations.

• Providing tobacco prevention materials in Bright Start Welcome Boxes to reinforce the message of not smoking during future pregnancies and preventing secondhand smoke exposure for infants and young children.

• Collaborating with DSS to develop and distribute a pregnancy resource folder for pregnant women which includes tobacco prevention messages.

• Providing tobacco prevention education materials and technical assistance to health care

providers as requested.

• Continuing collaboration with March of Dimes, Perinatal Association, American Cancer Society, and CHAD to educate professionals about the risks associated with smoking during pregnancy.

• Continuing to meet with Healthy Start staff to build relationships, obtain data, and provide tobacco prevention materials/technical support.

• Conducting media campaign "I Will Keep You Safe" targeting pregnant women.

c. Plan for the Coming Year

• Promote South Dakota QuitLine for pregnant women.

• Provide tobacco prevention education materials and technical assistance to health care providers as requested.

• Collaborate with March of Dimes, Perinatal Association, American Cancer Society, and CHAD to educate professionals about the risks associated with smoking during pregnancy.

• Risk assess pregnant clients and provide tobacco cessation/referral services to clients.

• Continue meeting with Healthy Start staff to build relationships, obtain data, and provide tobacco prevention materials/technical support.

• Conduct statewide public education/media campaign targeting pregnant women.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.5	17	17	22	22
Annual Indicator	21.7	23.5	22.2	24.1	25.9
Numerator	13	14	13	14	15
Denominator	59965	59469	58689	58105	57894
Data Source				Death Certificate	Death Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24.2	24	23	22	22

Notes - 2009

2007-2009 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2007-2009 South Dakota population estimates.

Notes - 2008
2006-2008 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2006-2008 South Dakota population estimates.

Notes - 2007
2005-2007 South Dakota death certificate data. Numerators and denominators are 3-year averages. Rate based on 2004-2006 South Dakota population estimates.

a. Last Year's Accomplishments
• Partnered with DHS to fund the Front Porch Coalition and HELP!Line Center to: (1) provide consultation and support to suicide awareness partnership actvities including distribution of promotional materials for the National Suicide Prevention Lifeline phone number as well as provided additional ASIST trainings for caregivers in suicide intervention; and (2) answer crisis line phone calls from across the state at the HELP!Line Centers through the National Suicide Prevention Lifeline to provide crisis assistance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in task force meetings sponsored by DHS				X
2. Present to crisis centers on the new suicide risk assessment instrument developed at the HELP! Line Center			X	
3. Update database of mental health providers/emergency services				X
4. Provide training for facilitators of suicide survivor support groups		X		
5. Provide consultation and support to the Garrett Lee Smith grant activities				X
6. Refine and update suicide prevention website				X
7.				
8.				
9.				
10.				

b. Current Activities
• Partnering with DHS to fund the HELP!Line Center to: (1) provide suicide prevention curriculum to secondary students; (2) improve suicide prevention policies and practices in schools; (3) provide communities with gatekeeper training, suicide intervention training, and clinical training for suicide assessment and treatment; (4) distribute suicide prevention information/materials to community caregivers and agencies; (5) augment the work of community-level suicide prevention task forces and initiative activities including support for resiliency curriculum in secondary schools, support for the development of programs for people grieving after a loss to suicide, providing Mental Health First Aid training, and reorganizing the South Dakota Strategy for Suicide Prevention (SDSSP) by bringing in community task force leaders; and (6) expand awareness of the SDSSP website and training community task force leaders to use the website to coordinate and share activities.

c. Plan for the Coming Year
• Partner with DHS to fund the HELP!Line Center to: (1) provide suicide prevention curriculum to secondary students and QPR to tribal schools; (2) improve suicide prevention policies and

practices in schools; (3) provide communities with gatekeeper training, suicide intervention training, and clinical training for suicide assessment and treatment; (4) distribute suicide prevention information/materials to community caregivers and agencies; (5) augment the work of community-level suicide prevention task forces and initiative activities including support for resiliency curriculum in secondary schools, support for the development of programs for people grieving after a loss to suicide, provide Mental Health First Aid training, and reorganize the SDSSP by bringing in community task force leaders; and (6) expand awareness of the SDSSP website and training community task force leaders to use the website to coordinate and share activities.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	89	90	87	87
Annual Indicator	87.8	87.4	86.6	86.4	87.8
Numerator	108	111	97	114	115
Denominator	123	127	112	132	131
Data Source				Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	87.8	87.9	87.9	88	88

Notes - 2009
2009 South Dakota birth certificate data

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data. The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates shows a slight downward trend. While the rates tend to decline over the years, there are no significant differences between the years statistically.

a. Last Year's Accomplishments
• Collaborated with DSVR to monitor the number of very low birth weight infants born at locations other than facilities with Level III nurseries.

• Collaborated with physician, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants, including preterm labor.

• Participated on March of Dimes Coalition to address issues related to prematurity.

• Assessed all pregnant women seen at local DOH offices for risks that have the potential to

affect pregnancy outcomes and provided ongoing education to clients on the signs of preterm labor.

• Collaborated with IHS to monitor prevalence of low birth weight infants among the American Indian population Healthy Start projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in March of Dimes Coalition to address issues related to prematurity.				X
2. Assess/educate women seen at DOH offices for risks affecting pregnancy outcomes.			X	
3. Educate women admitted to Baby Care/Bright Start on signs of preterm labor.			X	
4. Contract with Northern Plains Healthy Start to support direct services on reservations.				X
5. Obtain data on access to prenatal care and correlation of smoking to premature/low birth weight infants through Healthy Start contract.				X
6. Collaborate with March of Dimes and Perinatal Association to educate health professionals about risk factors associated with prematurity and low birth weight.				X
7.				
8.				
9.				
10.				

b. Current Activities

• Collaborating with DSVR to monitor the number of very low birth weight infants born at locations other than facilities with Level III nurseries.

• Collaborating with physician, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants, including preterm labor.

• Participating on March of Dimes Coalition to address issues related to prematurity.

• Assessing all pregnant women seen at local DOH offices for risks that have the potential to affect pregnancy outcomes and providing ongoing education to clients on the signs of preterm labor.

• Providing Bright Start Home Visiting Program in Sioux Falls, Rapid City, and Pine Ridge.

• Collaborating with IHS to monitor prevalence of low birth weight infants among the American Indian population via Healthy Start projects.

• Collaborating through designated local CHN offices and Preconception Health Survey Project to assess preconception health of childbearing-age women.

c. Plan for the Coming Year

• Collaborate with DSVR to monitor the number of very low birth weight infants born at locations other than facilities with Level III nurseries.

• Collaborate with physician, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants, including preterm labor.

• Participate on March of Dimes Coalition to address issues related to prematurity.

• Assess all pregnant women seen at local DOH offices for risks that have the potential to affect pregnancy outcomes and provide ongoing education to clients on the signs of preterm labor.

• Provide Bright Start Home Visiting Program in Sioux Falls, Rapid City, and Pine Ridge.

• Collaborate with Northern Plains Healthy Start to collect data and address disparities.

• Collaborate through designated local CHN offices and Preconception Health Survey Project to assess preconception health of childbearing-age women.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	80	80	69.8	69.8
Annual Indicator	79.2	68.5	69.7	67.7	65.7
Numerator	9086	8160	8544	8179	7841
Denominator	11466	11914	12253	12074	11930
Data Source				Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	70.3	70.3	70.3

Notes - 2009
2009 South Dakota birth certificate data. Trimester of prenatal care for 2006 and after was determined using date last normal menses began and date of first prenatal care visit. Data for 2005 used the month prenatal care began provided on the birth certificate.

Notes - 2008
2008 South Dakota birth certificate data. Trimester of prenatal care for 2008 was determined using date last normal menses began and date of first prenatal care visit. Data prior to 2006 used the month prenatal care began provided on the birth certificate.

Notes - 2007

2007 South Dakota birth certificate data. The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester shows a downward trend. While the rates indicate a downward trend, caution should be used in interpreting the data due to a change in the way this data are collected. The trimester of prenatal care data for 2006 and later are determined using date last normal menses began and date of first prenatal care visit while data prior to 2006 used the months prenatal care began provided on the birth certificate.

a. Last Year's Accomplishments

• Encouraging pregnant clients seen at local DOH offices and delegate family planning sites to access early and regular prenatal care.

• Partnering with Medicaid to provide risk assessments and case management services to pregnant women to improve pregnancy outcomes.

• Facilitating access to early prenatal care for pregnant women enrolled in Bright Start, Baby Care, and WIC.

• Collecting data from IHS for clients utilizing Healthy Start for pregnancy testing.

• Distributing the 2009 Perinatal Health Risk Assessment Survey Report and posting report on DOH website.

• Providing prenatal care services through mobile health clinic van on Pine Ridge Reservation which provide additional access to prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage pregnant clients seen at DOH offices and delegate family planning sites to access early and regular prenatal care.			X	
2. Partner with Medicaid to provide risk assessments and case management services to pregnant women to improve pregnancy outcomes.				X
3. Contract with Northern Plains Healthy Start to provide direct services to reservations.				X
4. Provide pregnancy test kits to Healthy Start sites.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Encouraging pregnant clients seen at local DOH offices and delegate family planning sites to access early and regular prenatal care.

• Partnering with Medicaid to provide risk assessments and case management services to pregnant women to improve pregnancy outcomes.

• Facilitating access to early prenatal care for pregnant women enrolled in Bright Start, Baby Care, and WIC.

• Collecting data from IHS for clients utilizing Healthy Start for pregnancy testing.

• Distributing the 2009 Perinatal Health Risk Assessment Survey Report and posting report on DOH website.

• Providing prenatal care services through mobile health clinic van on Pine Ridge Reservation which provide additional access to prenatal care.

c. Plan for the Coming Year

• Encourage pregnant clients seen at local DOH offices and delegate family planning sites to access early and regular prenatal care.

• Partner with Medicaid to provide risk assessments and case management services to pregnant women to improve pregnancy outcomes.

• Facilitate access to early prenatal care for pregnant women enrolled in Bright Start, Baby Care, and WIC.

• Provide pregnancy test kits to Healthy Start sites and South Dakota reservations to facilitate access to pregnancy testing and early referral to prenatal services.

• Increase public awareness of signs and symptoms of pregnancy and importance of early prenatal care.

D. State Performance Measures

State Performance Measure 2: *The rate (per 1,000 live births)of infants under age one who die as a result of Sudden Infant Death Syndrome.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.2	1.2	1.1	0.8	0.8
Annual Indicator	0.9	0.8	0.8	0.9	0.9
Numerator	10	9	9	11	11
Denominator	11276	11573	11878	12080	12086
Data Source				Birth and death certificate	Birth and death certificate
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0.7	0.7	0.7	0.7	

Notes - 2009

2007-2009 South Dakota birth and death certificate data - 3 year averages

Notes - 2008

2006-2008 South Dakota birth and death certificate data - 3 year averages

Notes - 2007
2005-2007 South Dakota death certificate data – 3-year averages. The rate of infants (per 1,000 live births) under age one who die as a result of SIDS shows a downward trend. While the rates trend downward, none of the rates are significantly different than the other due to the small numbers. Three-year averages were used to stabilize the rates somewhat but the small numbers still result in large confidence intervals making significant differences unlikely.

a. Last Year's Accomplishments
• Promoted the "Back to Sleep" campaign to educate parents and other caregivers on how to reduce SIDS deaths and the importance of laying babies on their backs to sleep.

• Collaborated with DSS to include SIDS and "Back to Sleep" materials in the Bright Start Welcome Boxes.

• Collaborated with Bright Start home visit nurses, Healthy Start contacts, local health councils, DOH staff, Head Start, and registered/licensed day care providers to promote "Back to Sleep" campaign with new parents.

• Participated in Project Impact listserv and trainings to stay current on SIDS information.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote Back to Sleep campaign through Bright Start, Healthy Start, day cares, etc.			X	
2. Include Back to Sleep materials in Bright Start Welcome Boxes.				X
3. Participate in Project Impact listserv and trainings to stay current on SIDS information.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Promoting the "Back to Sleep" campaign to educate parents and other caregivers on how to reduce SIDS deaths and the importance of laying babies on their backs to sleep.

• Collaborating with DSS to include SIDS and "Back to Sleep" materials in the Bright Start Welcome Boxes.

• Collaborating with Bright Start home visit nurses, Healthy Start contacts, local health councils, DOH staff, Head Start, and registered/licensed day care providers to promote "Back to Sleep" campaign with new parents.

• Participating in Project Impact listserv and trainings to stay current on SIDS information.

c. Plan for the Coming Year

• This state performance measure is being discontinued because it was determined during the needs assessment process that other partners in the state are currently addressing, and will continue to address, this issue.

State Performance Measure 3: *Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	38	38	38	33.4	33.2
Annual Indicator	37.4	37.2	33.4	33.9	35.0
Numerator	4466	4591	4229	4256	4356
Denominator	11949	12356	12670	12568	12450
Data Source				Birth certificate	Birth Certificate
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	33.2	33	33	33	

Notes - 2009

Prorated 2009 South Dakota birth certificate data based on 2009 Perinatal Health Risk Assessment Survey data and 2009 South Dakota abortion data

Notes - 2008

Prorated 2008 South Dakota birth certificate data based on 2007 Perinatal Health Risk Assessment Survey data and 2008 South Dakota abortion data

Notes - 2007

Prorated 2007 South Dakota birth certificate data based on the 2007 Perinatal Health Risk Assessment Survey data and 2007 South Dakota abortion data.

a. Last Year's Accomplishments

• Provided family planning services to 10,381 clients in CY09. Of these clients, 7,304 were women over the age of 19 and 2,858 were adolescents aged 19 and under. Of the total clients, 8,169 were at or below 150 percent of poverty and 11,063 women accessed a method of birth control.

• Provided community education regarding reproductive health/family planning to 1,193 adults during CY09.

• Received additional Title X directed supplemental funding to provide cost effective and efficacious contraceptives, increase the number of clients receiving services, and provide rapid HIV testing during the family planning visit.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide family planning services to women at risk of unintended pregnancy.			X	
2. Provide community education to individuals/groups regarding			X	

reproductive health and family planning.				
3. Seek additional funding to provide cost effective/efficacious contraceptives and community efforts/partnerships.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Providing counseling, education, medical, and contraceptive services to women at risk of unintended pregnancy.

• Providing community education to individuals and groups regarding reproductive health/family planning topics.

• Seeking additional funding through Title X directed supplemental funds to provide cost effective and efficacious contraceptives.

c. Plan for the Coming Year

• Provide family planning services to populations at high risk for unintended pregnancy.

• Provide community education to individuals and groups regarding reproductive health and family planning topics.

• Collaborate with other agencies and offices with similar missions to address unintended pregnancy.

State Performance Measure 4: *Percent of high school youth who self-report tobacco use in the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	28	28	24.7	24.5
Annual Indicator	28.0	28.0	24.7	24.7	23.2
Numerator	12315	12315	10757	10757	10000
Denominator	43981	43981	43550	43550	43104
Data Source				YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24.5	24.4	24.4	24.3	

Notes - 2009

2008/2009 South Dakota school enrollment based on 2009 Youth Risk Behavior Survey data

Notes - 2008

2006/2007 South Dakota school enrollment based on 2007 Youth Risk Behavior Survey data

Notes - 2007
2006-2007 South Dakota school enrollment based on 2007 Youth Risk Behavior Survey data. The 2007 YRBS shows a decrease in the percent of high school youth who are current smokers. In 2007, 11% report spit tobacco use which was down from 13% in the 2005 survey. The Tobacco Control Program collaborates with the Department of Education to collect tobacco usage data through the YRBS. South Dakota repeats the survey every two year.

a. Last Year's Accomplishments
• Served on DHS Alcohol and Drug Abuse Council.

• Provided QuitLine materials to CHN offices to facilitate efforts to inform parents and the community about the health effects of smoking, secondhand smoke and spit tobacco.

• Collaborated with other state agencies to administer the YRBS in South Dakota high schools.

• Provided QuitLine referral materials to DOH field offices, medical providers, tribal health, and other partners.

• Utilized Prevention Resource Centers (PRCs) to distribute educational materials regarding tobacco use.

• Conducted public education campaign targeting youth and focusing on the effects of tobacco use and secondhand smoke.

• Encouraged/supported participation of schools and youth in local tobacco prevention coalitions.

• Provided statewide cessation services via the QuitLine at no cost to the caller.

• Partnered with DOE to support and incorporate tobacco prevention education in schools.

• Partnered with DHS to support and incorporate tobacco prevention in several South Dakota communities.

• Offered tobacco prevention grants to all South Dakota K-12 public, private, and tribal school districts with an enrollment of 100 students or more; provided $537,900 to 84 school districts through grants.

• Provided resources for the Bright Start Welcome Box about the dangers of exposing newborns and children to secondhand smoke.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sponsor community coalitions working on tobacco prevention at the local level.				X
2. Implement tobacco prevention education model in schools.			X	
3. Conduct countermarketing campaigns at state and local level.			X	
4. Provide statewide telephone-based tobacco cessation services at no cost to the caller.			X	
5. Utilize data from YRBS and Youth Tobacco Survey to refine program activities to address specific populations with higher tobacco use including high school and middle school students.				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities

• Disseminating a tobacco prevention tool kit to all South Dakota K-12 school districts. Copies of the tool kit are being delivered to all grantee schools and also available on the TCP website for downloading by non-grantee schools.

• Disseminating a tobacco prevention tool kit to all South Dakota post-secondary schools.

• Providing cessation services via the QuitLine at no cost to the caller.

• Collaborating with DOE to sponsor implementation of tobacco prevention education (LifeSkills) in South Dakota schools.

• Providing technical assistance and resources to DOH staff, community groups, schools, parents, health care providers, and others working on tobacco prevention.

• Conducting countermarketing/public education campaigns targeting youth.

• Providing Teens Against Tobacco Use (TATU) training to various groups of students around the state.

• Providing audiovisual messages to CHN offices and DSS Medicaid field offices to deliver tobacco prevention and cessation messaging to clients.

• Providing funding support for a web-based tobacco prevention program to be offered at no cost to all K-12 schools in South Dakota.

c. Plan for the Coming Year

• Provide cessation services via the QuitLine at no cost to the caller.

• Distribute grant funds for school and community partnerships to decrease tobacco use among children and young adults.

• Collaborate with DOE to conduct the YRBS.

• Collaborate with DOE to support LifeSkills training and curriculum for schools.

• Provide TATU training to students.

State Performance Measure 5: *Percent of school-aged children and adolescents with a Body Mass Index (BMI) at or above the 95th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	16.2	16	15.8	16.2	16
Annual Indicator	16.4	16.9	16.3	16.3	16.6

Numerator	5820	7647	6777	6036	6674
Denominator	35489	45251	41579	37028	40202
Data Source				SD School Height-Weight	SD School Height-Weight
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15.8	15.6	15.4	15.3	

Notes - 2009
2008/2009 South Dakota school year School Height and Weight data.

Notes - 2008
2007/2008 South Dakota school year School Height and Weight data. The rate of K-12 students who are at or above the 95th percentile BMI-for-age was 16.3% for 2006-2007 and 2007-2008 school years. NHANES IV results for 2003-2004 indicate that 18.8% of children ages 6-11 are above the 95th percentile and 17.4% of adolescents ages 12-19 are in this obese category.

Notes - 2007
2006/2007 South Dakota school year School Height and Weight data

a. Last Year's Accomplishments
• Collected and analyzed school height and weight data for the 2008-09 school year.

• Received data from 249 schools on 37,028 students for the 2007-08 school year; data collected showed 16.3% of South Dakota students were obese (BMI for age 95th percentile and above) and 33.1% are overweight or obese. The obese rate of 16.3% was the same as the previous year.

• Provided 26 balance beam scales and measuring boards to schools to improve school height-weight data quality and assist schools who wish to participate in the project but can't due to lack of equipment.

• Collaborated with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases especially those objectives and strategies focused on parents, caregivers, schools, and youth organizations.

• Provided print materials on child obesity to schools and others who serve youth and made materials available on the DOH website.

• Coordinated with DOE to support and/or assist schools with selection and implementation of comprehensive health education.

• Collaborated with DOE to develop and sponsor the South Dakota Schools Walk program which promotes walking in schools as a way to increase physical activity among youth and help combat obesity. All elementary teachers were invited to register their classes online and receive free incentives for their students. For the 2007-08 school year, 211 classrooms representing approximately 6,400 K-12 students and 310 staff participated. After school programs were invited to participate this year for the first time with over 3,000 students and nearly 300 staff involved.

• Co-sponsored SDSU Nutrition Seminar.

• Promoted a Clinical Obesity Toolkit for healthcare providers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, analyze, and interpret school height/weight data and distribute to health/education providers and promote computerized data collection system.				X
2. Provide balance beam scales and measuring boards to schools to improve school height-weight data.				X
3. Provide resources to increase physical activity for children/adolescents including strategies to decrease tv viewing, promoting "Turn Off the TV Week, and South Dakota Great Day of Play.			X	
4. Collaborate with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases.				X
5. Provide print materials on child obesity to schools and others who serve youth and make materials available on the DOH website.			X	
6. Collaborate with DOE to promote South Dakota School Walk to schools and out-of-school time programs.				X
7. Sponsor seminars on pediatric obesity-related topics.			X	
8.				
9.				
10.				

b. Current Activities

• Collecting/analyzing school height-weight data for 2009-10 school year; provided data from 2008-2009 school year back to the participating 223 schools representing 40,202 students.

• Providing 26 balance beam scales/measuring boards to schools to improve school height-weight data collection.

• Providing resources to increase physical activity for children/adolescents including strategies to decrease tv viewing, promoting "Turn Off the TV Week" and the "South Dakota Great Day of Play", and providing Healthy South Dakota posters to schools.

• Collaborating with partners to implement strategies in the Nutrition and Physical Activity State Plan to Prevent Obesity and Other Chronic Disease; assisted in the development of the 2010 plan.

• Promoting South Dakota Schools Walk program in collaboration with CSHP to K-6 grade schools and out-of-school time programs; implementing mileage club.

• Using the CSHP electronic newsletter "NewsInfused" to share information with public, private, tribal, and Bureau of Indian Affairs schools in the state.

• Co-sponsoring SDSU Nutrition Seminar and presenting data and information about pediatric obesity.

• Contracting with Educational Service Agency to manage a pilot project for educators on effective health and physical education curriculum, instruction, and assessment through the development of a regional-based training plan.

c. Plan for the Coming Year

• Provide nutrition and physical activity expertise.

• Collect, analyze, and interpret available height-weight data for school-aged children and distribute information to appropriate health and education providers in an effort to reduce the percent of overweight children.

• Encourage schools to use computerized data collection system to submit height-weight data.

• Provide education information and materials to DOH staff and others for use with parents and schools on how to increase physical activity and healthy eating for all ages of children.

• Utilize healthysd.gov website to provide updated consumer and provider resources on overweight children and adolescents.

• Collaborate with South Dakota Park and Recreation Association, GFP and other interested agencies to promote "South Dakota Great Day of Play".

• Promote National Turn off the TV Week in collaboration with program partners.

• Implement 2010 Nutrition and Physical Activity State Plan to Prevent Obesity and Other Chronic Diseases objectives and activities to address obesity in schools.

• Implement Educational Service Agency pilot project for educators on effective health and physical education curriculum, instruction, and assessment through the development of a regional-based training plan.

State Performance Measure 8: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		70	70	73.9	74
Annual Indicator	69.7	72.5	73.9	74.8	71.4
Numerator	8313	8962	9454	9425	8872
Denominator	11928	12356	12792	12593	12426
Data Source				Birth certificate	Birth certificate
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	74	74.1	74.1	74.1	

Notes - 2009
2009 South Dakota birth certificate data

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota Metabolic Screening Program data.

The percentages of mothers who breastfeed their infants at hospital discharge shows an upward

trend. The last two years of data shows a significant difference over the other years with the 2007 data also being significantly different from the 2006 data.

a. Last Year's Accomplishments

• Participated with the South Dakota Breastfeeding Coalition to promote World Breastfeeding Week and obtained a Governor's proclamation for World Breastfeeding Week. Collaborated with WIC to develop, purchase, and distribute materials for World Breastfeeding Week and ongoing marketing of breastfeeding.

• Educated mothers in the Bright Start home visiting program, WIC, and Baby Care programs on the benefits of breastfeeding and provided support and encourage to initiate and continue breastfeeding.

• Provided information to health professionals, hospitals, work sites, and the public promoting breastfeeding through the Breastfeeding Peer Counselor program.

• Partnered with the Nutrition and Physical Activity programs to provide resources to prenatal/breastfeeding educators to improve breastfeeding rates as well as highlighting breastfeeding on the DOH and HealthySD.gov websites and promoted two brochures on returning to work and breastfeeding.

• Implemented a Breastfeeding Peer Counselor Program to work with pregnant and breastfeeding WIC clients in Beadle, Butte, Charles Mix, Davison, and Roberts counties. The local programs have received training on the breastfeeding peer counselor program and how they can work as a team to educate and support breastfeeding WIC participants.

• Collected breastfeeding initiation rates for the state and by individual hospital via the Newborn Screening Program. Sent letters to hospitals with their individual rates and materials on how to increase and support breastfeeding.

• Offered breastfeeding classes to WIC clients at local agencies and collaborated with hospitals, clinics, and community resources to refer WIC clients to breastfeeding classes when not available in office.

• Loaned electric breast pumps to MCH and WIC clients to encourage continued breastfeeding and address high percentage of South Dakota working mothers. Also provided program participants with manual breast pumps as needed.

• Distributed bimonthly WIC Wellness Nutrition Fun Facts newsletters to WIC participants containing breastfeeding educational materials.

• Developed and implemented a statewide plan to improve breastfeeding rates through the state plan breastfeeding goals and objectives.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect breastfeeding initiation rates for the state and by individual hospitals.		X		
2. Provide electric breast pumps to MCH/WIC clients to encourage continued breastfeeding.		X		
3. Serve on the Breastfeeding Coalition.				X
4. Educate mothers in various DOH programs on the benefits of breastfeeding and provide support/encouragement to initiate and			X	

continue breastfeeding.				
5. Provide and update breastfeeding information on the DOH and HealthySD.gov website.			X	
6. Partner with Nutrition and Physical Activity programs to provide resources to prenatal/breastfeeding educators.				X
7. Contract with Breastfeeding Consultant to provide breastfeeding peer counselors to the WIC program.				X
8.				
9.				
10.				

b. Current Activities

• Participating with the South Dakota Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion and to promote World Breastfeeding Week.

• Educating mothers in the Bright Start Home Visiting, WIC, and Baby Care programs on the benefits of breastfeeding and providing support and encouragement to initiate and continue breastfeeding.

• Enhancing partnerships with Medicaid and health professionals to encourage more women to breastfeed.

• Providing updated breastfeeding information on the DOH and HealthySD.gov websites.

• Collaborating with WIC to develop/purchase and distribute materials for ongoing marketing of breastfeeding.

• Partnering with the Nutrition and Physical Activity programs to provide resources to prenatal/breastfeeding educators as well as develop and implement a statewide plan to improve breastfeeding rates.

• Expanding Breastfeeding Peer Counselor program for WIC clients to include Codington, Brown, Lawrence, and Shannon counties.

• Changing policy and procedure within the WIC program to assure more regular contact with prenatal women to encourage and demonstrate benefits of breastfeeding to increase initiation, exclusivity, and duration rates.

• Setting statewide and local agency goals to increase initiation and duration of breastfeeding.

• Preparing RFP for breastfeeding media campaign and development of Physician's Toolkit to promote breastfeeding support by healthcare providers.

c. Plan for the Coming Year

• This state performance measure is being discontinued because the MCH felt the new state performance measure to increase breastfeeding duration will also impact breastfeeding initiation.

State Performance Measure 9: *Percent of singleton birth mothers who achieve a recommended weight gain during pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2005	2006	2007	2008	2009

Data					
Annual Performance Objective		21	22	29.5	29.7
Annual Indicator	20.8	30.4	29.5	30.9	30.7
Numerator	195	3498	3505	3604	3574
Denominator	936	11524	11876	11650	11623
Data Source				Birth certificate	Birth certificate
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29.7	30	30	30	

Notes - 2009
2009 South Dakota birth certificate data

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data. The percent of singleton birth mothers who achieve a recommended weight gain during pregnancy shows an upward trend. While the rates indicate an upward trend, caution should be used in interpreting this data due to a change in the way the data are collected. 2006 and newer data are taken from the birth certificate data while data prior to 2006 were collected with the South Dakota Perinatal Health Risk Assessment survey.

a. Last Year's Accomplishments
• Researched problem of excessive weight gain during pregnancy to better define the problem.

• Provided training for WIC, Bright Start, and Baby Care staff regarding appropriate weight gain during pregnancy.

• Revised and developed DOH materials related to appropriate weight gain during pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Educate mothers in WIC and perinatal programs about appropriate weight gain during pregnancy.			X	
2. Assist pregnant women identify behavior changes and community resources to assist them in achieving appropriate weight gain during pregnancy.				X
3. Provide training opportunities for WIC, Baby Care, Bright Start staff and other health care professionals on appropriate weight gain during pregnancy.				X
4. Develop tool kit of resources to assist in addressing appropriate prenatal weight gain.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Convening workgroup to address appropriate weight gain during pregnancy.

• Developing and distributing a tool kit of educational and other resources for health care providers to address appropriate weight gain with pregnant women.

• Supporting prenatal weight gain educational session by two OB/GYN physicians through Grand Rounds and Perinatal Association.

• Including prenatal weight gain information on "I Didn't Know" website.

• Assisting pregnant women identify behavior changes and community resources to assist them in achieving appropriate weight gain during pregnancy.

• Educating mothers on WIC, perinatal programs, and home visiting program about appropriate weight gain during pregnancy.

c. Plan for the Coming Year
• Educate pregnant women in WIC and perinatal programs about appropriate weight gain during pregnancy.

• Educate professionals on appropriate weight gain during pregnancy and risks associated with less than or more than recommended prenatal weight gain.

• Continue prenatal weight gain workgroup to determine other interventions to address appropriate prenatal weight gain.

• Support "I Didn't Know" website.

• Develop and revise DOH materials related to appropriate pregnancy weight gain.

State Performance Measure 10: *Percent of infants exposed to secondhand smoke.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		14.5	14.5	9.4	9.4
Annual Indicator	14.6	14.6	9.4	9.4	8.1
Numerator	137	137	84	84	58
Denominator	936	936	896	896	720
Data Source				SD Perinatal Health Risk Assessment	SD Perinatal Health Risk Assessment
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.3	9.3	9.2	9.2	

Notes - 2009
2009 South Dakota Perinatal Health Risk Assessment Survey data.

Notes - 2008
2007 South Dakota Perinatal Health Risk Assessment Survey data

Notes - 2007
2007 South Dakota Perinatal Health Risk Assessment Survey data.

a. Last Year's Accomplishments
• Conducted secondhand smoke public education campaign.

• Provided tobacco prevention messaging in Bright Start Welcome Boxes.

• Risk assessed all mothers in the Baby Care and Bright Start Nurse Home Visiting programs for smoking behaviors three months prior to pregnancy as well as during pregnancy.

• Provided education, resources, and referrals to all moms who indicate either smoking behaviors or exposure to secondhand smoke within their environment.

• Strongly recommended smoking cessation or limiting/eliminating exposure to secondhand smoke strategies to assist those moms that have quit smoking to remain tobacco free.

• Provided cessation services via the QuitLine at no cost to the caller.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Risk assess all mothers regarding smoking behaviors and exposure to secondhand smoke.			X	
2. Provide educational materials and resources to mothers regarding effects of tobacco use on them, their developing fetus, and their other children.			X	
3. Make referrals as needed for smoking cessation strategies as well as strategies to limit or eliminate exposure to secondhand smoke.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Working with DSS staff to include tobacco prevention messaging in Bright Start Welcome Boxes.

• Risk assessing all mothers in the Baby Care and Bright Start Nurse Home Visiting programs for smoking behaviors three months prior to pregnancy as well as during pregnancy.

• Providing cessation services via the QuitLine at no cost to the caller.

c. Plan for the Coming Year

• Provide secondhand smoke materials for the Bright Start Welcome Boxes.

• Risk assess all mothers in the Baby Care and Bright Start Nurse Home Visiting programs for smoking behaviors three months prior to pregnancy as well as during pregnancy.

• Provide cessation services via the QuitLine at no cost to the caller.

• Conduct statewide secondhand smoke public education campaign specifically targeting pregnant women and mothers of young children.

E. Health Status Indicators

Introduction

Ongoing review of the Health Status Indicators provides the DOH and MCH program with information on the state's population to assist in directing public health efforts. The review of the indicators is one of many pieces of ongoing data efforts that allow the MCH program to analyze and evaluate current programs and services, identify gaps in services, review goals and objectives, and enhance collaboration with partners, if necessary. The MCH team uses this data to examine existing capacity and assist programs in aligning efforts not only within the MCH program but within the overall DOH 2020 initiative.

The South Dakota MCH surveillance system utilizes indicators such as demographics, education, income, WIC participation, health status of both mom and baby, prenatal care, pre/post health behaviors, tobacco use, and family support to drive policy and programs throughout the state. Surveillance systems used include BRFSS, Tribal PRAMS, Youth Tobacco Survey, YRBS, Medicaid, hospital discharge, birth/death certificate, Perinatal Health Risk Assessment Survey, oral health survey, and Dakota Smiles Mobile Dental Program. South Dakota uses the surveillance system data for (1) program planning, (2) implementing programs, (3) assessing program effectiveness, and (4) improving program accountability.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.6	7.0	7.0	6.5	5.9
Numerator	758	838	853	783	700
Denominator	11466	11914	12253	12074	11930
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

2009 South Dakota birth certificate data

Notes - 2008

2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data.

Narrative:
The percent of live births weighing less than 2,500 grams shows slight downward trend. While the rates fluctuate between years, only 2009 is significantly different than 2006 and 2007.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.1	5.5	5.3	4.7	4.7
Numerator	574	631	624	551	545
Denominator	11158	11524	11876	11650	11623
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota birh certificate data

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data

Narrative:
The percent of live singleton births weighing less than 2,500 grams shows a slight downward trend. While the rates fluctuate, none of the rates are significantly different between years.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.1	1.1	0.9	1.2	1.1
Numerator	131	135	114	139	133
Denominator	11466	11914	12253	12074	11930
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota birh certificate data

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data

Narrative:
The percent of live births weighing less than 1,500 grams shows a flat trend. While the percents fluctuate, none are significantly different between years.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.9	0.9	0.8	0.8	0.9
Numerator	101	108	93	91	106
Denominator	11158	11524	11876	11650	11623
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota birh certificate data

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data

Narrative:
The percent of live singleton births weighing less than 1,500 grams shows an almost flat trend. While the percents fluctuate, none are significantly different between years.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	18.9	13.0	13.9	11.1	11.0
Numerator	29	20	22	18	18
Denominator	153650	153650	158365	161819	163841

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2007-2009 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2007-2009 South Dakota population estimates.

Notes - 2008
2006-2008 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2006-2008 South Dakota population estimates.

Notes - 2007
2007 South Dakota birth certificate data. Rate based on 2006 South Dakota population estimates.

Narrative:
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger shows a downward trend. While the rates tend to fluctuate between years, none are significantly different between years. The numbers used to calculate these rates are relatively small and tend to yield confidence intervals larger than larger numbers of events. The numbers used to calculate the rates for 2007 and forward are three-year averages to comply with the small number guideline.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	10.3	7.1	5.1	3.1	4.3
Numerator	16	11	8	5	7
Denominator	155916	155916	156390	161819	163841
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2007-2009 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2007-2009 South Dakota population estimates.

Notes - 2008
2006-2008 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2006-2008 South Dakota population estimates.

Notes - 2007

2005-2007 South Dakota death certificate data. Numerator and denominators are 3-year averages. Rates are based on 2004-2006 South Dakota population estimates.

Narrative:
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes shows a downward trend. While the rates trend downward, none of the rates are significantly different that the other due to small numbers. Three-year averages were used to stabilize the rates somewhat but the small numbers still result in large confidence intervals making significant differences unlikely.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	36.4	40.6	29.6	29.0	32.1
Numerator	44	49	35	34	39
Denominator	120734	120734	118168	117167	121490
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota death certificate data. Rate are based on 2009 South Dakota population estimates.

Notes - 2008
2008 South Dakota death certificate data. Rates are based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota death certificate data. Rate based on 2006 South Dakota population estimate.

Narrative:
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years shows a slight downward trend. While the rates fluctuate, none of the rates are significantly different between years.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0	0	181.1	180.5	185.9
Numerator			293	296	308
Denominator			161799	164011	165712

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Association of Healthcare Organizations hospital discharge data. Rate based on 2009 South Dakota population estimate and 2009 community hospital discharges only.

Notes - 2008
2008 South Dakota Association of Healthcare Organizations hospital discharge data. Rate based on 2008 South Dakota population estimate and 2008 community hospital discharges only.

Notes - 2007
2007 South Dakota Association of Healthcare Organizations hospital discharge data. Rate based on 2007 South Dakota population estimate and 2007 community hospital discharges only.

Narrative:
The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger shows a slight upward trend. While the rates fluctuate between years, none are significantly different between years.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	309.1	355.4	286.3	261.0	285.4
Numerator	475	546	457	428	473
Denominator	153650	153650	159647	164011	165712
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Department of Public Safety Accident Records data. Rate based on 2008 South Dakota population estimate.

Notes - 2008
2008 South Dakota Department of Public Safety Accident Records data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota Department of Public Safety Accident Records data. Rate based on 2006 South Dakota population estimates.

Narrative:
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children 14 years and younger shows a slight downward trend. While the rates fluctuate, only the 2006 rate is significantly different from 2007, 2008, and 2009.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1,717.0	1,633.3	1,556.3	1,496.2	1,424.0
Numerator	2073	1972	1839	1753	1730
Denominator	120734	120734	118168	117167	121490
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Department of Public Safety Accident Records data. Rate based on 2008 South Dakota population estimate.

Notes - 2008
2008 South Dakota Department of Public Safety Accident Records data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota Department of Public Safety Accident Records data. Rate based on 2006 South Dakota population estimates.

Narrative:
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years shows a slight downward trend. While the rates fluctuate between years, the 2007, 2008, and 2009 rates are significantly different from 2005 while only 2009 is significantly different than 2006.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	26.1	26.2	23.7	28.7	28.4
Numerator	753	754	663	800	807
Denominator	28827	28827	27957	27901	28424
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Department of Health communicable disease data. Rate based on 2008 South Dakota population estimate.

Notes - 2008
2008 South Dakota Department of Health communicable disease data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota Department of Health communicable disease data. Rate based on 2006 South Dakota population estimate.

Narrative:
The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia shows a slight upward trend. While the rates tend to fluctuate between years, only 2007 is significantly different from 2008 and 2009.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.7	8.5	9.3	10.7	11.2
Numerator	1102	1083	1149	1330	1405
Denominator	127289	127289	123957	124611	125080
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 South Dakota Department of Health communicable disease data. Rate based on 2008 South Dakota population estimate.

Notes - 2008
2008 South Dakota Department of Health communicable disease data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota Department of Health communicable disease data. Rate based on 2006 South Dakota population estimate.

Narrative:

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia shows an upward trend. While the rates tend to fluctuate between years, the 2008 and 2009 rates are significantly different from other years.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	12342	9876	195	1620	151	10	490	0
Children 1 through 4	47298	36746	1113	7159	586	22	1672	0
Children 5 through 9	53496	42322	1220	7489	708	47	1710	0
Children 10 through 14	52576	42394	1052	7009	522	32	1567	0
Children 15 through 19	58571	48472	933	7378	415	27	1346	0
Children 20 through 24	62919	53735	940	6339	669	78	1158	0
Children 0 through 24	287202	233545	5453	36994	3051	216	7943	0

Notes - 2011

Narrative:
Based on US Census Bureau population estimates for 2009, the 0-24 population racial composition consist of 81.3 percent White, 12.9 percent American Indian and 3.1 percent to the remaining minorities of which 2.8 percent were allocated to the multiple race classification. The estimates for those age 24 years and younger have increased 1.2 percent between 2008 and 2009. All the race category population estimates listed have increased from 2008. The White estimate increased 1.5 percent and the American Indian increased 2.0 percent from 2008.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	11761	581	0
Children 1 through 4	44289	3009	0
Children 5 through 9	50137	3359	0
Children 10 through 14	50373	2203	0
Children 15 through 19	56645	1926	0
Children 20 through 24	61034	1885	0
Children 0 through 24	274239	12963	0

Notes - 2011

Narrative:
The Hispanic population for this age group has also increased 12.6 percent from 2008 to 2009. The ages 0-14 increased in numbers by 1.0 percent between the years 2008 and 2009 while the ages 15-24 increased in numbers by 3.7 percent.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	10	4	0	5	0	0	1	0
Women 15 through 17	303	147	15	114	1	0	26	0
Women 18 through 19	789	475	12	244	5	1	52	0
Women 20 through 34	9653	7727	161	1405	105	4	240	11
Women 35 or older	1175	977	30	117	24	1	22	4
Women of all ages	11930	9330	218	1885	135	6	341	15

Notes - 2011

Narrative:
The overall number of births decreased 1.2 percent from 2008 to 2009. The categories showing increases were Black or African American 17.8 percent, Native Hawaiian or Other Pacific Islander 20.0 percent (small numbers) and the multi race category 12.9 percent. The categories showing decreases were: White 1.1 percent, American Indian 5.4 percent and Asian 3.6 percent.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	8	2	0
Women 15 through 17	279	24	0
Women 18 through 19	727	60	2
Women 20 through 34	9303	344	6
Women 35 or older	1130	44	1
Women of all ages	11447	474	9

Notes - 2011

Narrative:
The non-Hispanic births decreased by 1.4 percent and Hispanic births increased by 3.0 percent. The births in two age groups increased; 2.2 percent in the 18-19 group and 1.8 percent in the 35+ group. The births in the other age groups decreased; 28.6 percent in the <15 group, 12.2 percent in the 15-17 group and 1.4 percent in the 20-34 age group.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	80	56	3	19	0	0	2	0
Children 1 through 4	12	9	0	2	1	0	0	0
Children 5 through 9	13	10	0	2	0	0	1	0
Children 10 through 14	14	8	0	5	0	0	1	0
Children 15 through 19	58	33	0	24	0	0	1	0
Children 20 through 24	63	39	1	22	0	0	1	0
Children 0 through 24	240	155	4	74	1	0	6	0

Notes - 2011

Narrative:
The overall number of deaths among those 24 years old and younger increased 2.1 percent from 2008 to 2009. All but one of the race categories increased in numbers. Those races with increasing numbers were White 5.4 percent and American Indian 8.8 percent. The other minority numbers were too small to provide meaningful statistics.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	78	2	0
Children 1 through 4	11	1	0
Children 5 through 9	10	3	0
Children 10 through 14	14	0	0
Children 15 through 19	55	3	0
Children 20 through	60	3	0

24			
Children 0 through 24	228	12	0

Notes - 2011

Narrative:
There was no change in the Non-Hispanic deaths for this age group from 2008 to 2009. The Hispanic or Latino numbers were too small to provide meaningful statistics.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	221461	178464	4150	30284	1826	152	6585	0	2008
Percent in household headed by single parent	20.9	17.0	39.9	41.4	0.0	0.0	0.0	30.0	2009
Percent in TANF (Grant) families	2.4	0.7	0.0	13.0	0.0	0.0	0.0	1.8	2009
Number enrolled in Medicaid	76269	38525	3759	30348	702	0	0	2935	2009
Number enrolled in SCHIP	18818	12822	710	4191	244	0	0	851	2009
Number living in foster home care	2820	963	169	1662	16	6	0	4	2009
Number enrolled in food stamp program	39717	20189	1400	15704	294	83	2047	0	2009
Number enrolled in WIC	27602	17416	897	7508	194	111	1472	4	2009
Rate (per 100,000) of juvenile crime arrests	3720.5	2971.8	8225.9	7191.6	2546.3	0.0	0.0	4881.9	2009
Percentage of high school drop-outs (grade 9 through 12)	4.6	2.3	4.0	17.2	1.7	0.0	0.0	7.3	2009

Notes - 2011
2008 population estimates

2000 Census

SFY 2009

FFY2009

FFY2009

July 2009

SFY 2009

SFY 2009

2008/2009 school year

SFY 2009

Narrative:
The data used to prepare this indicator are from various agencies many outside the DOH. These agencies collected data in ways inconsistent with one another. Some agencies do not update unknown data after the records are initially entered and therefore have large unknown categories. When this data is used to calculate population-based rates, unreliable statistics are generated. Many of the agencies collect the race information differently than the DOH and some do not collect ethnic data. Therefore the data provided for this indicator are difficult to compare between lines due to the differences in collection methods and are best used for comparing the same lines to previous years' data.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	211392	10069	0	2009
Percent in household headed by single parent	20.0	30.8	0.0	2009
Percent in TANF (Grant) families	0.0	0.0	2.4	2009
Number enrolled in Medicaid	73620	2649	0	2009
Number enrolled in SCHIP	18045	773	0	2009
Number living in foster home care	0	0	2820	2009
Number enrolled in food stamp program	38649	1068	0	2009
Number enrolled in WIC	25430	2168	4	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	3720.5	2009
Percentage of high school drop-outs (grade 9 through 12)	4.6	6.7	0.0	2009

Notes - 2011

2008 population estimates

2000 Census

SFY 2009

FFY 2009

FFY 2009

July 2009

SFY 2009

SFY 2009

2008/2009 school year

SFY 2009

Narrative:
The data used to prepare this indicator are from various agencies many outside the DOH. These agencies collected data in ways inconsistent with one another. Some agencies do not update unknown data after the records are initially entered and therefore have large unknown categories. When this data is used to calculate population-based rates, unreliable statistics are generated. Many of the agencies collect the race information differently than the DOH and some do not collect ethnic data. Therefore the data provided for this indicator are difficult to compare between lines due to the differences in collection methods and are best used for comparing the same lines to previous years' data.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	77464
Living in urban areas	112862
Living in rural areas	71056
Living in frontier areas	43563
Total - all children 0 through 19	227481

Notes - 2011

Narrative:
The data used in this indicator are 2000 Census data. This is the most recent data available with the level of detail needed.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total

Total Population	727425.0
Percent Below: 50% of poverty	5.8
100% of poverty	13.2
200% of poverty	33.1

Notes - 2011

Narrative:
The data used in this indicator are 2000 Census data. This is the most recent data available with the level of detail needed.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	198003.0
Percent Below: 50% of poverty	8.1
100% of poverty	17.2
200% of poverty	41.1

Notes - 2011

Narrative:
The data used in this indicator are 2000 Census data. This is the most recent data available with the level of detail needed.

F. Other Program Activities

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants -- MCH perinatal program staff at the state, regional, and community level provide services, offer technical assistance, and partner with other agencies to improve the health of pregnant women, mothers, and infants and impact pregnancy outcomes. Staff in the community provide direct case management and education services, link clients with appropriate resources, and collaborate with public and private partners to assure access to services. Nurse home visiting programs modeled after the David Olds model are available in Rapid City, Sioux Falls, and Pine Ridge. Quality of services is assured through formalized activities at the state and local level. Client education materials are made available for both agency staff and private partners to utilize in the provision of services to this population. Training for professionals is provided directly or through collaboration with other agencies.

Preventive/Primary Care Services for Children and Adolescents -- DOH staff at the state, regional, and community level provide services, offer technical assistance, and partner with other agencies to improve the health of children and adolescents. Staff in the community provide developmental/social-emotional screening, immunizations, school screenings, health fairs, health education for school-age children, and parent education and participate locally on various advisory groups such as child protection teams, coordinated school health councils, interagency teams, etc. They share information and resources to facilitate referral to programs (i.e., SCHIP, food stamps, and heating assistance) and work with state agencies, organizations, communities, and partners to provide technical assistance to promote MCH programs. Program staff also

participate on several workgroups facilitated by other state agencies.

Services for CYSHCN -- State CSHS staff participate in numerous activities to enhance the capacity of the health and related service systems to identify and refer CYSHCN in a timely and efficient manner. Networking and public education activities are ongoing by program staff. These activities also provide opportunities to discuss service delivery and other issues impacting CYSHCN. MCH funds assist in the provision of respite care services for CYSHCN, with staff also assisting in the application process as appropriate. The CSHS program director also represents the program on the State Interagency Coordinating Council for Birth to Three and Parent Connection Family to Family Advisory Council as well as various other workgroups and committees at the state level.

G. Technical Assistance

The MCH program is committed to assuring all MCH populations in the state receive the highest quality care and have optimal health. The MCH program is seeking technical assistance in two areas: (1) assessing the impact of national health care reform legislation on MCH programs and populations in South Dakota; and (2) examining hospital practices related to promoting breastfeeding by mothers at hospital discharge.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	2252548	1192966	2252548		2252548	
2. Unobligated Balance *(Line2, Form 2)*	0	550833	0		0	
3. State Funds *(Line3, Form 2)*	1718000	1571312	1718000		1718000	
4. Local MCH Funds *(Line4, Form 2)*	250000	343685	250000		250000	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	472000	241496	472000		472000	
7. Subtotal	4692548	3900292	4692548		4692548	
8. Other Federal Funds *(Line10, Form 2)*	15044959	14961021	16122511		16859960	
9. Total *(Line11, Form 2)*	19737507	18861313	20815059		21552508	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	840000	599065	840000		764933	
b. Infants < 1 year old	375000	330190	375000		375000	
c. Children 1 to 22 years old	1455000	1209940	1455000		1500000	
d. Children with	1600000	1317054	1600000		1617067	

Special Healthcare Needs						
e. Others	290000	309801	290000		300000	
f. Administration	132548	134242	132548		135548	
g. SUBTOTAL	4692548	3900292	4692548		4692548	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		93713	
c. CISS	0		0		0	
d. Abstinence Education	68190		136379		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	13393663		14472303		15351728	
h. AIDS	0		0		0	
i. CDC	222980		227044		216849	
j. Education	0		0		0	
k. Other						
Title X	1265482		1192141		1197670	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	310000	278423	310000		328478	
II. Enabling Services	1005548	542836	1005548		656957	
III. Population-Based Services	1200000	1409786	1200000		1689317	
IV. Infrastructure Building Services	2177000	1669247	2177000		2017796	
V. Federal-State Title V Block Grant Partnership Total	4692548	3900292	4692548		4692548	

A. Expenditures

Activities performed by MCH program and field staff that provide services funded by the MCH block grant are accounted for by a daily time study. The time study includes funding codes that reflect the population being served (i.e., child/adolescent, pregnant women, mothers and infants, and CYSHCN). Function codes determine if the service was direct, enabling, population-based, or infrastructure. Examples of this are developmental screening, immunization administration, travel to provide services, training, networking, quality assurance, and case management.

The budget amounts reflect anticipated activities of program and field staff but actual expenditures can vary based on the state economy and public health events (i.e., outbreaks, natural disasters). South Dakota law prohibits deficit spending so the Governor and state Legislature control the spending of general funds that in turn affect dollars that are available for MCH block grant match.

B. Budget

MCH block grant funds have historically been used to address DOH priorities as outlined in the needs assessment and annual plan of the MCH block grant application. The comprehensive needs assessment process assists the DOH in setting priorities for resource allocation. The amount of funding allocated to MCH services is determined as part of the state budget process that includes development of the budget by the DOH, interim approval by the Bureau of Finance and Management (BFM) and Governor's Office, and final approval by the state Legislature.

The budget outlines areas for which Title V funds will be allocated. Development of the budget complies with the "30-30" requirement for primary and preventive care and special health care needs for children and adolescents and is consistent with the requirements to limit administrative costs to no more than ten percent. The DOH maintains the overall level of funds for MCH at the level established in FFY 1989.

Appropriation of general funds for MCH state match is at the discretion of the Legislature, Governor's Office, and DOH. State match funding sources are state funds (including general funds appropriate by the Legislature), local match, program income, and other sources (i.e., Don't Thump Your Melon project private partners). No foundation or other private funding is currently available or utilized. The level of funds utilized from each match source varies from one year to the next based on availability of funds and the state's allocation process. Increasing inflationary costs have depleted revenue reserves within the DOH and the state as a whole and required shifts in match fund sources.

Budget development is subject to rules and requirements set by BFM dictating both the process and content of the budget, including availability of funds and limitations on authorization levels. State MCH programs were first required to use the current format of reporting budgets and expenditures (including levels of the pyramid) in FFY 1999. Since that time, South Dakota has been refining the budget development and expenditure process to meet both state and federal rules and requirements. The DOH continues to work to move to accounting programs that more easily reflect population group and pyramid level reporting requirements. The DOH and other state agency partners are reviewing potential grant opportunities in the area of maternal, infant, and childhood home visiting, abstinence, and Personal Responsibility Education program. All of these opportunities would impact the MCH population in South Dakota if received.

Direct Health Services: A portion of the MCH block grant has traditionally been allocated to health service delivery (state-employed CHNs and nutritionists/dietitians) based on DOH time study data. For Alliance sites, services are contracted out to private agencies with DOH staff providing technical assistance to communities and maintaining its role of assessment, assurance, and evaluation. DOH time study data tracks actual time spent delivering MCH services and activities. CHNs, dietitians, and nutritionists provide MCH services statewide to assure a local delivery system of quality public health services. The budget reflects the projected allocations to assure provision of postpartum/MCH home visits and family planning services. This allocation of funds enables a system of service delivery to assure essential health care services are available in rural areas of the state. The DOH continues to move to reduction of direct health care services when appropriate.

Enabling Services: MCH block grant funds support activities to enhance access to care and assist consumers receive needed services (i.e., Bright Start toll-free number, care coordination for CYSHCN and their families, translation, respite care, and parent support activities).

Population-Based Services: Allocations in this area support newborn metabolic screening, coordinated school health, injury prevention, oral health, school screenings, community immunization coalitions, immunizations, outreach and public education, risk assessment of pregnant women, child health conferences/developmental screenings, and breastfeeding activities.

Infrastructure Building Services: Allocations in this area provide funding to support program staff, benefits, travel, operating, training, supplies, materials, capital outlay, and contractual services. Activities funded include needs assessment, community coordination/collaboration, community assistance, quality assurance, policy development, program planning and evaluation, interagency collaboration, training, technical assistance to field staff and public/private partners, and data collection and analysis.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.